THE BACK DOCTORS WELLNESS CLINIC

Most of our new patients have been referred to our clinic by their family and friends, nevertheless, they are not necessarily fully aware of the steps we take before we accept a patient for care. In every case we conduct a consultation interview through which we learn as much as possible about the patient and their condition. We believe it is important to explore the history that has led up to the symptoms you are now experiencing.

After the consultation is complete, a comprehensive evaluation and examination follows. When the cause of the presenting condition is discovered, your doctor may initiate treatment on the first day. Spinal x-rays may be required in some cases to better determine the cause of your condition and the duration of care.

Your treatment program will be outlined to you when your doctor determines the rate of your body's Response to the care provided. Exercises and lifestyle changes may be recommended to enhance your progress.

Chiropractic treatment consists of spinal adjustments that are directed towards misaligned vertebrae (subluxations) to restore normal movement and balance to the spine and achieve optimum nervous system health.

Our goal at The Back Doctors is to create a caring, family oriented environment, through which we will help as many people in our community as possible to maximize their health and to get the most out of life.

The following is a confidential patient health record. To ensure a thorough examination and diagnosis, please complete all questions on the following pages as best possible.

Date:________________ MSP PHN#____________________ ICBC/WCB/DVA_________________________

File number:_________________________

Name:____**Birth date**:__________________________**Sex**: **M / F**

Address:____**PC**:_____________________

Telephone: (**H**)_________________(**W**)_________________**Occupation**:__________________________________

Married_________**Single**_________**# of Children**_________________**Ages**:________________________________

Family Physician____________________________________**Date of last Consult**:_______________________

How did you hear about our office?____

I can be reached at by text at:_________________________**Carrier:**________________

My Email address is:____

Office use only:

Diagnosis:____

____

Past Health History

1) Have you ever had X-Rays? NO___________ YES____________

2) Which body parts and when?____

3) Have you ever had any of the following:

Major surgeries/operations? What? When? ___________________________________

Broken bones? Which ones and when? ____

Major accidents or falls/injuries? When? ____________________________________

Hospitalizations? When? For what? ____

Major sicknesses/Illness? What? When? ____________________________________

Previous Chiropractic Care? Who? When? ___________________________________

4) Do you take any prescription or non-prescription medications? No_________ Yes_________

What kinds? ____

5) Have you ever experienced any complications with any of the following systems?

Nerve or Nervous system? If so what type? __________________________________

Digestive problems? If so what type? ______________________________________

Muscle, Bone or Joint conditions? If so what type? ___________________________

Heart or blood vessels/ Circulation? If so what type? _________________________

Chest or Respiratory? If so what type? _____________________________________

Genital or Urinary? If so what type? _______________________________________

Immunological? If so what type? ____

6) Do you exercise? _________How much & how often? ________________________

7) Do you smoke/Drink/use drugs? ____

How much & how often? ____

DOCTOR'S NOTES:

Present State of Health

1) What is the purpose of this appointment?____

2) When did this condition begin? ____

3) How did this condition begin? ____

4) Has this condition occurred before? ____

5) What seems to aggravate the condition? ____

6) What seems to relieve the condition? ____

7) Have you had prior treatment for the condition? No ____________ Yes _____________

8) When and by whom? ____

9) Is the condition becoming? Better ________ Worse ________ Staying the same ________

10) Does this condition interfere with . . . Work _________ Sleep _________ Exercise _________

Family Life ________ Other ____

11) How bad is the pain on average? ________________

No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

12) How bad is the pain at its worst? _________________

No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

13) How would you describe your condition? ___________

____

____

14) Do you have any other complaints? ________________

____

____

Please fill out the following pain diagram:

X = Pain **T** = Tingling **S** = Stiffness
O = Numbness **B** = Burning * = Other_______

Doctor's Notes: