Lifeforce Proactive
HEALTH CENTRE

Date: _____ Case #: _____

First Name: _____ Last Name: _____

Birth Date: M ____ D ____Y ____ __ Age _____ Care Card # :_____

Address: _____ City: _____

Province: _____ Postal Code: _____ Best Contact Number: _____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Type of Work: _____ Extended Insurance? ■Yes ■ No

Email Address for Appointment Reminders: _____

HEALTH HISTORY

Is this visit a result of a Motor Vehicle Accident or Work Safe BC Injury? ■ Yes ■ No

If yes, please advise the receptionist for appropriate ICBC or WCB form.

- Family Dr.: _____Location:_____
- May we communicate health concerns with your Medical Doctor? ■ Yes ■ No
- Purpose of this Appointment? _____
- What is your primary complaint? _____
- When did this condition begin? _____
- Is your condition getting better, worse or staying the same? _____
- What aggravates your condition? _____
- What relieves your condition? _____
- Are there others in your family with this same condition? ■ Yes ■ No
- Have you seen any other health practitioner's for this condition? ■ Yes ■ No

  If yes, Who?_____
- Medication you are taking now ■ Nerve pills ■ Pain Killers/Muscle Relaxers ■ Blood Pressure ■ Insulin ■ Aspirin/Similar ■ Other _____

  If yes, for what condition? _____
- Major Illnesses / Surgery / Operations? _____
- Major accidents or Falls _____
- Hospitalization (other than above) _____
- Family history of illness or Disease _____

  _____
- Have you ever had X-rays before? ■ Yes ■ No
- If yes, when and why? _____

Please Circle Referral Source

Patient

_____

Practitioner

_____

Live in Area
Website
Social Media
Health Talk
Google Searched
Dr._____
Other

_____

Females only

- When was your last period _____ Are you pregnant? ■ Yes ■ No If Yes, Due date _____
- Did you have severe back pain during or after your pregnancy? ■ Yes ■ No # of Children _____
- Do you experience menstrual irregularity or cramping? ■ Yes ■ No
- Are you Menopausal ■ Yes ■ No Date of Last Bone Density Assessment_____

Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these symptoms can affect your overall course of care.

CIRCLE ANY OF THE FOLLOWING SYMPTOMS YOU HAVE HAD IN THE PAST 6 MONTHS

MUSCULO-SKELETAL
- Low Back Sciatic Pain
- Hip Pain
- Knee Pain
- Foot Pain
- Ankle Pain
- Walking Problems
- Joint Pain
- Joint Stiffness
- Headache
- Neck Pain
- Jaw Pain – Clicking
- Pain Between Shoulders
- Shoulder Pain
- Rib Pain
- Arm Pain
- Elbow Pain
- Wrist Pain
- Hand Pain
- Osteoporosis
- Arthritis
- Fibromyalgia

CARDIOVASCULAR
- Chest Pain
- Shortness Of Breath
- Blood Pressure Problems
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke
- Aneurysm / Blood Clots
- Bruise easily
- Take ASA / Blood Thinners

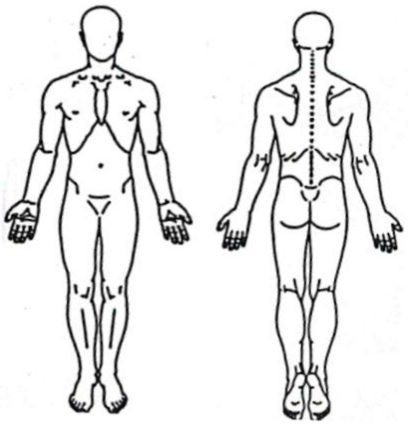
EYES EARS NOSE THROAT
- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Smell Or Taste Problems

GENERAL
- Fatigue
- Allergies
- Loss of Sleep
- Cancer
- Skin Disorders
- Contagious Disease (ie: TB or Hepatitis B)

NERVOUS SYSTEM
- Stress
- Nervous
- Paralysis
- Convulsions
- Dizziness
- Forgetfulness
- Confusion
- Depression
- Epilepsy
- Fainting
- Numbness
- Cold / Tingling Extremities
- Muscle Spasm
- Muscle Weakness

MALE / FEMALE
- Breast / Pain Lumps
- Prostate/SexualDysfunction
- Bowel Bladder Control Loss

PLEASE OUTLINE ON THE DIAGRAM YOUR AREAS OF PAIN



GASTRO-INTESTINAL
- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Ulcers
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Colitis

GENITO-URINARY
- Bladder Trouble
- Painful/Excessive Urination
- HIV / AIDS

PLEASE INDICATE ANY OF THE FOLLOWING YOU WOULD LIKE INFORMATION ON:
- LaserCare Therapy
- Custom Orthotics
- Massage Therapy
- Exercise Specialist
- Bone Density Testing
- Body Composition Testing
- Other _____

STRESS Please rate the severity of your stress in each area
(With 0 being no stress and 5 being unbearable stress):
- General Stress 1 2 3 4 5
- Work-Related Stress 1 2 3 4 5
- Personal Stress 1 2 3 4 5

GENERAL HEALTH INFORMATION
- How would you rate your activity level? **Low Moderate High**
- Have you ever worn foot orthotics? **Yes No**
- How many hours do you sleep at night? **0-4 4-6 6-8 8-10+**
- Do you drink coffee on a regular basis? **Yes No**
- Do you smoke? **Yes No**
- Do you take recreational drugs? **Yes No**
- Rate your alcohol consumption? **None Low Moderate High**
- Do you take Nutritional Supplements? **Yes No**
- Do you think you need to? **Yes No**