ARIA
HEALTH & WELLNESS CLINIC

Dr. Amar Sandhu, D.C.

Name _____Care Card # _____

Date of Birth (mm/dd/yyyy) _____ Age_____ Sex M / F Height/ Weight _____

Address_____ City_____ Province_____ Postal Code_____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ Who referred you to our clinic? _____

Medical Doctor _____ Emergency Contact / # _____

Employer/Occupation _____ Are you currently registered as a student? Y / N

Do you have private insurance for chiropractic? Y / N If so how much is your annual benefit _____

Is this an ICBC/WCB claim? If yes ,circle one Claim #_____ Injury Date _____

Who did you see for the first treatment after your injury? (name/occupation) _____

Lawyer (if applicable) _____If WCB Occupation _____Employer _____

Work Address_____ Supervisor _____

What is the reason for your visit? _____

Please draw with an "X" the location of your complaint on the picture or use the following symbol(s):

Ache: AAA, Burning: BBB, Numbness: NNN, Pins/Needles: +++, Stabbing: ///, Stiff/Tight: 222, Shooting Pain: →→→

When did this condition start? _____

Has it occurred before? YES / NO

How did it happen? _____

Is this related to a job or auto accident? JOB AUTO NO

What makes it feel better? _____

What makes it feel worse? _____

Since it started, is it getting better or worse? Better / Worse

What is the severity 0 to 10 (0 = No Pain and 10 = Worst)? _____

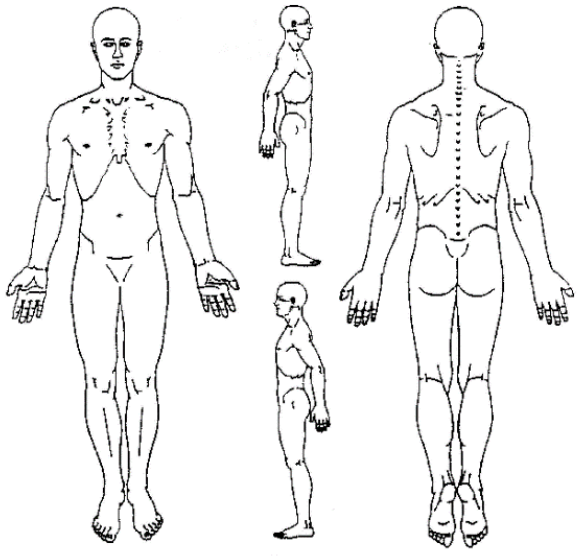
Does the pain radiate anywhere? YES / NO Where? _____

How often does the pain occur? _____

How long does the pain last? _____

Has your sleep been affected? _____

When do you feel the pain? _____



Medications and Surgery

Past Hospitalization or major illness?

_____

Surgeries and operations?

_____

Are you on any medications/ supplements/ over the counter drugs/ birth control? YES or NO

If yes please list? _____

Any allergies? _____

DO YOU HAVE A FAMILY HISTORY OF?

Back/ Neck Pain Cancer Diabetes Heart Problems High Blood Pressure Stroke Arthitris

DO YOU?

Smoke or chew tobacco: Yes, I currently smoke ____pack(s) / day, and have for _____years

No, but I used to. Quit how long ago? _____ How much did you smoke? _____

Never

Health History

Have you experienced any of the following? Please check all that apply

- ❑ Anemia
- ❑ Anxiety
- ❑ Arthritis
- ❑ Bleeding Abnormalities
- ❑ Blood in Urine or Stool
- ❑ Cancer
- ❑ Changes in vision, hearing, smell or taste
- ❑ Chest pain
- ❑ Constipation
- ❑ Contagious skin condition
- ❑ Depression
- ❑ Diabetes
- ❑ Difficulty breathing
- ❑ Dizziness
- ❑ Fatigue
- ❑ Fever/ chills
- ❑ Frequent Infections
- ❑ Gastrointestinal Problems
- ❑ Headaches
- ❑ Heart disease, heart attack
- ❑ High or low blood pressure
- ❑ High or low cholesterol
- ❑ HIV/ AIDS/ Hepatitis
- ❑ Insomnia
- ❑ Kidney or bladder problems
- ❑ Menstrual problems
- ❑ Night sweats
- ❑ Numbness or weakness
- ❑ Osteoporosis
- ❑ Persistent cough
- ❑ Phlebitis
- ❑ Pregnancy (current/past)
- ❑ Psoriasis
- ❑ Recent change in weight +/- 10lbs
- ❑ Scoliosis/ spinal curvature
- ❑ Seizures, fainting, epilepsy
- ❑ Stroke
- ❑ Swollen joints
- ❑ Varicose veins
- ❑ Other disease/disorder not listed*

* Please specify_____

Please describe your exercise habits

_____

_____

What are your goals for treatment?

_____

_____