PATIENT HISTORY FORM

Name: (Last) _____ (First) _____
Date of Birth: ___ mm ___dd ____yyyy **Age:** ____ **Gender:** Female ____ Male ____
Address: _____
City _____ Province _____ Postal Code_____
Phone: (home) _____ (mobile) _____
(work) _____
Email: _____

Occupation: _____ **Retired:** Y N
Medical Doctor: _____ Phone _____
Date of last appointment: _____ Date of last physical: _____

Emergency Contact: Name _____ Phone Number_____
Relationship _____

Care Card #: _____
Extended Medical Insurer _____
Do you have an open or pending ICBC or Worksafe claim? □ No □ Yes
Claim #: _____ Adjuster: _____ Phone: _____

How did you hear about our clinic? _____
Who referred you to our clinic? Name _____ Relationship _____
Has any other family member already been a patient at the clinic? _____

Please list *any* prescription medications, over the counter medications, vitamins, or supplements you are taking:
1) _____ **3)** _____
2) _____ **4)** _____

Known allergies: *(including medications, foods, seasonal, oils/lotions, etc.)*
_____

Have you ever been hospitalized? □ Y □ N If Yes, please list:
_____
Have you ever had surgery? □ Y □ N If Yes, please list:
_____
Falls and accidents: _____
Scars: _____

Please indicate if you believe any of the following apply to you:
(P = past C = current H = family history)

CARDIOVASCULAR/BLOOD
- □ Heart Attack
- □ High/Low Blood Pressure
- □ Stroke/Aneurysm
- □ Pace Maker
- □ Other Heart condition
- □ Varicose veins
- □ Thrombophlebitis
- □ Anemia
- □ Bruise or bleed easily
- □ Other Circulatory condition

MUSCULOSKELETAL
- □ Osteoporosis
- □ Arthritis
- □ Joint Dislocation/ Subluxation
- □ Bone Fracture
- □ Strains/Sprains
- □ Fibromyalgia

KIDNEY/URINARY
- □ Diabetes
- □ Kidney Disease
- □ Frequent Bladder Infections
- □ Other Urinary or Kidney condition

RESPIRATORY
- □ Asthma
- □ Chronic Sinusitis
- □ Chronic Colds
- □ Chronic Lung Infections
- □ Other Respiratory condition

DIGESTIVE
- □ Irritable Bowel Syndrome
- □ Constipation
- □ Colitis
- □ Crohn's Disease
- □ Ulcer/Heartburn/Acid Reflux
- □ Nausea

NEUROLOGICAL
- □ Spinal Injury
- □ Epilepsy/Seizures
- □ Dizziness/Fainting
- □ Other Neurological condition

HEAD
- □ Head Trauma
- □ Frequent Headaches
- □ Migraines/Cluster Headaches
- □ TMJ Disorder/Problems

SKIN
- □ Psoriasis
- □ Eczema
- □ Rashes/Hives
- □ Acne/Boils
- □ Other Skin condition

MENTAL HEALTH
- □ Anxiety
- □ Depression
- □ Mental Illness
- □ Insomnia
- □ Fatigue

OTHER
- □ Transplant
- □ Implants
- □ Cancer
- □ HIV
- □ Hepatitis
- □ Contagious Condition

WOMEN'S HEALTH
- □ Painful Menses
- □ Pregnant
  # of weeks: _____
  # of Pregnancies: _____
- □ Endometriosis
- □ Ovarian Cysts
- □ Uterine Fibroids

Other therapy/treatment (past or present):

□ Acupuncture	Date of last visit	_____
□ Chiropractor	"	_____
□ Massage Therapy	"	_____
□ Naturopath	"	_____
□ Physiotherapy	"	_____
□Other	"	_____

List any activities/sports/hobbies you are regularly involved in or enjoy:
(ie. Jogging, Hockey, Yoga, Reading, etc.) _____

Circle the answer closest to how you presently feel:
(1 = poor 5 = excellent)

Quality of sleep	1	2	3	4	5
Energy level	1	2	3	4	5
Eating habits	1	2	3	4	5
Stress level	1	2	3	4	5
Exercise habits	1	2	3	4	5

Hours of sleep per night: ____ Do you awake feeling rested? Y N
Number of meals you regularly eat per day: ____
Number of times you exercise per week: ____
Do you smoke? Y N Occasionally
Do you drink alcohol? Y N Occasionally

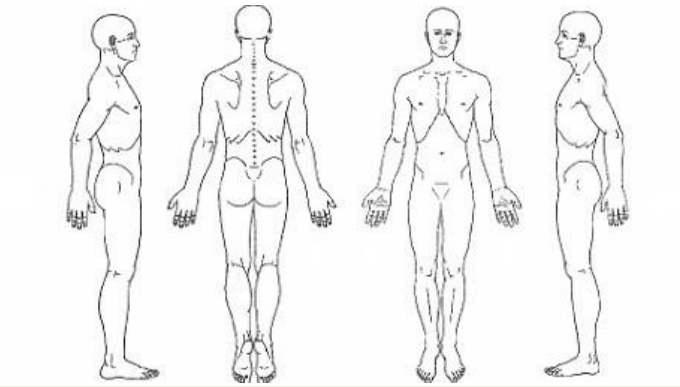
CURRENT CONDITION:

Please describe your current condition and symptoms: _____
_____
How long have you had this condition? _____
Have you had this condition before? Y N

How did it start? _____
What aggravates it? _____
What relieves it? _____
How is this condition affecting/interfering with your daily activities? *(ie. Work, exercise, avoiding certain activities or movements, etc.)* **_____**
Have you tried other treatments for this condition? _____
If yes, have they helped? Y N
Have you seen a Medical Doctor for this condition? Y N

On a daily basis, where does your condition sit on a pain scale of 0 - 10?
(0 = no pain, 10 = greatest pain)
1 2 3 4 5 6 7 8 9 10
Where does your condition sit on a pain scale *right now*?
(0 = no pain, 10 = greatest pain)
1 2 3 4 5 6 7 8 9 10
Please circle the types of pain or symptoms this condition creates:
Aching Burning Numbness Pins & Needles Stabbing
Other: _____

Please circle on the diagram below where you have pain or discomfort:



Your appointment time has been reserved for you. Please understand that missed appointments prevent us from helping other patients. We ask you to honour this by showing for your appointments and providing us with a minimum of 24 hours if you need to reschedule. Failure to do so may result in a full treatment fee. Thank you for your respect.

I have answered the above questions to the best of my knowledge. I authorize Port Moody Integrated Health and its associated Practitioners to communicate with each other as deemed necessary for my beneficial treatment. I give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature _____ Date _____