PATIENT HISTORY FORM

Name (Last) _________________________ (First) _____________________ (Initial) _____

Date of Birth ____ yyyy ___ mm ___ dd **Age** ____ **Gender** Female ____ Male ____

Address ____

City ________________________________ Province _____ Postal Code__________

Phone ___________________________ Please circle Landline / Cell / Work

___________________________ Please circle Landline / Cell / Work

Email ____

BC Care Card # ________________________________

Occupation _______________________________________ **Retired** Y N

Medical Doctor _________________________ Phone ___________________

Date of last appointment ______________ Date of last physical _____________

Date of last dental examination _________

Name of Extended Medical Insurer _______________________________________

ICBC or WorksafeBC if yes, please circle Claim # _____________________________

Emergency Contact Name _______________________ Phone Number_____________

Relationship __________________

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 __________

If so, please give name ____

GENERAL

Height ________

Weight _______ lbs Weight 1 year ago _______

Maximum weight _______ When ____________

CONTEXT of CARE REVIEW

Successful health care and preventative medicine are possible only when we have a complete understanding of the patient mentally, physically, and emotionally. The nature of your responses to the following questions will go a long way in assisting our understanding of your truest desires. Your time, thoughtfulness, and honesty in completing this overview will greatly aid us in addressing your health needs.

1) What brings you here today

2) Why did you choose Port Moody Integrated Health

3) What short term expectations do you have from today's visit

4) What long term expectations, if any, do you have from working with your practitioner at Port Moody Integrated Health

5) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle (10 being 100% committed)

   0 1 2 3 4 5 6 7 8 9 10

6) a) What behaviours or lifestyle habits do you currently engage in regularly that you believe support your health

   b) What behaviours or lifestyle habits do you currently engage in regularly that you believe are less constructive lifestyle habits

7) What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you

Please list any prescription medications, over the counter medications, vitamins, or supplements you are taking

1) ____________________________ **4)** ____________________________
2) ____________________________ **5)** ____________________________
3) ____________________________ **6)** ____________________________

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

____

____

Other therapy/treatment (past or present)

	Date of last visit
☐ Acupuncture	__________
☐ Chiropractor	__________
☐ Massage Therapy	__________
☐ Naturopath	__________
☐ Physiotherapy	__________
☐Other	__________

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
Exercise habits	1	2	3	4	5
Stress level	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

FAMILY HISTORY

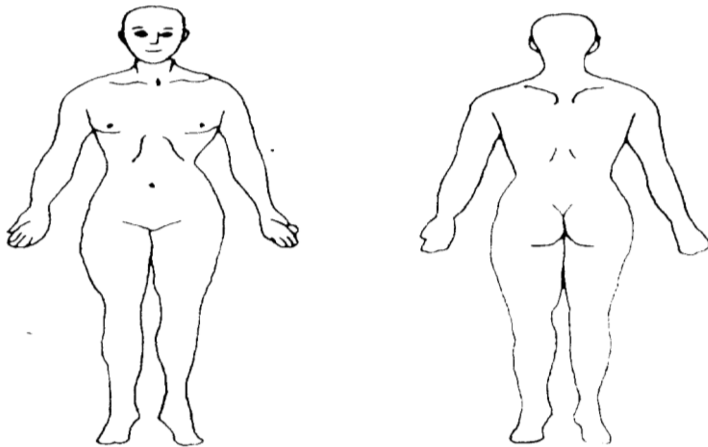
Do you have a family history of any of the following (Please circle)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney Disease	Osteoporosis	Arthritis	Asthma/Hayfever
Tuberculosis	Stroke	Anemia	Mental Illness

Please list your health concerns in order of importance

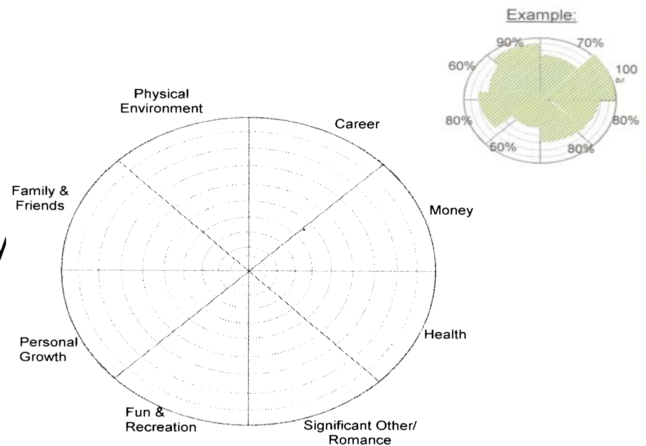
1) ____
2) ____
3) ____
4) ____
5) ____

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



WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.
For example, if you are extremely happy in your career, shade the entire career pie shape starting at the centre point radiating outwards.



Is there anything else you would like to add or comment on ______________
____

If you require more space, please use reverse of this page.

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 arriving for your appointments on time and providing us with a minimum of 24 hours notice 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 telephone numbers and email address I have provided. I also understand that my personal and medical information is confidential and will be disclosed to third parties only with my written permission.

Signature ________________________________ Date ___________________

Thank you for your time and effort.
Our team looks forward to providing you with the best possible care.