Rosstown Chiropractic

New Patient Health History Form

Name: ____________________________ Birthdate (m/d/y):_____________________________

Address: __________________________ Postal Code: ________________________________

City: _____________________________ Employer: __________________________________

Phone #: (Home) ___________________ Occupation: _________________________________

Phone #: (Cell) ____________________ How did you hear about us?:___________________

BC Care Card #: ___________________ E-mail Address: ____________________________

Family Physician:___________________

Is this a Workers Compensation Claim? ☐ Yes ☐ No Claim # _________________________

Is this an ICBC Claim? ☐ Yes ☐ No Claim # _________________________

Past Chiropractic care? ☐ Yes ☐ No Chiropractor name/location_____________________

Have you used foot orthotics in the past 5 years? ☐ Yes ☐ No

Please list current medications:

____

Reason(s) for consulting our office?

____

____

Please tell us about any conditions from childhood *up to* _PRESENT_:

☐ Auto accident? Explain: ______________________________

☐ Work injury? ______________________________

☐ Sports injury? ______________________________

☐ Work stress? ______________________________

☐ Family/home stress? ______________________________

☐ Non-prescription drug use? ______________________________

☐ Ever been hospitalized? ______________________________

☐ Surgery? ______________________________

☐ Any illnesses? ______________________________

☐ Limited exercise? ______________________________

☐ Poor nutrition? ______________________________

Anything else? ______________________________

Please check ✓ any conditions which presently cause you a problem. Please Circle any which were problem in past

- ☐ Headaches
- ☐ Dizziness
- ☐ Ringing in Ears
- ☐ Fainting
- ☐ Earache
- ☐ Vision problems
- ☐ Sinus Problems
- ☐ Hearing Problems
- ☐ Nose Bleeds
- ☐ Sore Throat
- ☐ Fever
- ☐ Weight Loss
- ☐ Dental Problems
- ☐ Depression
- ☐ Asthma
- ☐ Numbness/pain in arms/legs
- ☐ Eye pain
- ☐ Trouble swallowing
- ☐ Eczema
- ☐ Skin eruptions
- ☐ Rashes
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Bed wetting
- ☐ Prostate problems
- ☐ Sexual dysfunction
- ☐ Anemia
- ☐ Thyroid
- ☐ Gas/bloating
- ☐ Nausea/vomiting
- ☐ Constipation/diarrhea
- ☐ Colitis
- ☐ Black/bloody stool
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Gall bladder trouble
- ☐ Heart problems

Please check any of the following you have had:

- ☐ Alcoholism
- ☐ Heart Disease
- ☐ Allergies
- ☐ Arthritis
- ☐ Hypoglycemia
- ☐ Cancer
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Rheumatic Fever

<u>Females Only:</u>

- ☐ Lumps/pain in breast
- ☐ Menopausal symptoms
- ☐ Hot flashes

Are you currently pregnant? ☐ Yes ☐ No

I understand that all fees are to be paid in full at the time of service, unless other arrangements have been made and agreed upon in writing. Individuals under ***Premium Assistance*** may have up to 10 visits partially reimbursed. It is my responsibility to verify by contacting BC Health and to notify Rosstown Chiropractic if I qualify for Premium Assistance benefits. I also understand that there is a **$20 charge for missed appointments** with less than 24 hours notice.

Signature:_________________________________ **Date:**____________________

I give permission for Rosstown Chiropractic (drarbez@shaw.ca rosstownchiro@rosstownchiropractic.com) to send emails/text messages pertinent to my care at this office (ex: appointment reminders, appointment booking, video stretches, etc.). This authorization will expire on my request.

Signature:_________________________________ **Date:**____________________