Welcome to Balance Chiropractic Inc.

Name:	Date of Birth:
Mailing Address:	Care Card: Medical Doctor: Wellness Team:
☐ Home Phone: ☐ Cell Phone: ☐ Work Phone: ☐ Email: *Please indicate your preferred method of contact*	Emergency Contact: Relationship: Phone Number: *In an emergency, may I contact this person?*

Each of us is an expression of our personal journey during this lifetime. Within the details of that story is your path to wellness. Please attach additional reports or sheets of paper to create a complete picture of who *you* are today. I thank you ahead of time for committing this time to your wellness! Let us start where all good journeys are created: *at the beginning*.

Birth

What number child are you, out of how many?
Were there any complications during your mother's pregnancy with you?
Was your birth at term?
Was it a natural onset labor, or induced?
Was it a vaginal birth or cesarean?
If it was a vaginal birth, were instruments used (vacuum, forceps)?
If it was a cesarean, what were the circumstances requiring a c-section?

Accidents & Injuries

Please list <u>*all*</u> the traumatic emotional events that have occurred during your lifetime, *including dates*.

Please list <u>*all*</u> of the accidents or injuries sustained during your lifetime, *including dates*.
These may include, but are not limited to:

- all motorized accidents (vehicle, ATV, snowmobile, etc)	- all falls on the bum, especially if you were unable to sit
- any injury sustained with velocity (skiing, biking, horse, etc)	- all fractures, stitches and injuries requiring rehabilitation
- any injury to the head, especially if loss of consciousness	- all sports-related injuries
- any time you had the wind knocked out of you	- all work-related injuries, whether they were claimed or not

Personal Medical History

What medical conditions have you been diagnosed with? Please indicate which you are receiving treatment for.
(*breathing, heart, blood pressure, digestive, urinary, diabetes, thyroid, arthritis, depression, cancer, etc.*)

Please list all of the surgical procedures you have undergone.
Include wisdom teeth, exploratory surgeries of joints/abdomen, colonoscopies, tubal ligation/vasectomy, eye surgery, etc.

What prescription medication are you currently taking, *including dosage*?

What vitamins or nutritional supplements do you take? *Where did you buy them?*

Female Medical History

Menstruation History ~

At what age did you begin menstruation (menarche)? *Did you have menstrual complaints?*
Have you ever been on the birth control pill? *For how long?*
As an adult, did you have menstrual complaints?
Are you experiencing symptoms related to perimenopause?
At what age did you experience menopause?
Have you ever experienced bleeding more than one year after your menstruation had stopped?

Pregnancy History ~

Did you have any difficulties getting pregnant?
How many pregnancies have you had? How many children have you had?
Were the lost pregnancies due to miscarriage or abortion?
Explain the pregnancy, labor and delivery of each of your children, *including dates*.

Please indicate if you have been diagnosed with any of the following;

☐ Endometriosis	☐ Uterine Fibroids	☐ Fibrocystic Breast Disease
☐ Polycystic Ovarian Syndrome	☐ Uterine or Ovarian Cancer	☐ Breast Cancer

Male Medical History

Please indicate if you are experiencing, or have been diagnosed with any of the following;

☐ Erectile Dysfunction	☐ Benign Prostate Hypertrophy (BPH)	☐ Prostate or Testicular Cancer

Family Medical History

What medical conditions have your immediate family members (parent, sibling, child) been diagnosed with?

What medical conditions are on your mother's side of the family (grandparents, aunts, uncles)?

What medical conditions are on your father's side of the family (grandparents, aunts, uncles)?

Health & Wellness Support Team

Please indicate the name of the practitioners you have tried in the following modalities:

☐ Chiropractor	☐ Acupuncturist
☐ Osteopath	☐ Naturopath
☐ Physiotherapist	☐ Medical Qi Gong Therapist
☐ Massage Therapist	☐ Therapeutic Yoga / Pilates
☐ Craniosacral Therapist	☐ Other (*please indicate*)

Diet & Lifestyle

Are you, or have you ever been a smoker/chew tobacco? (*how long, how many packs a day*?)

Are you, or have you ever been a drinker? (*what form of alcohol, how long, how many drinks a day?)*

Are you, or have you participated in recreational drugs? (*what form of drug, how long, how many a day?)*

Are you on a special diet? *Is it due to dietary sensitivities or allergies?*
Where are you currently employed, and how many hours a week are you working?

How many hours a week of physical activity do you participate? (*please indicate which activities*)

How many hours a week of creative activity do you participate? (*please indicate which activities*)

Overall, how would you rate your health - Excellent Good Fair Poor

What are you passionate about in your life?

Present Complaints

Please indicate if you have experienced any of the following symptoms for longer than 1 month;

☐ fever, sweats or chills	☐ frequent or severe headaches	☐ indigestion, heartburn
☐ loss of appetite, nausea	☐ sensitivity to light	☐ difficulty swallowing
☐ fatigue, malaise, weakness	☐ coordination, balance problem	☐ abdominal pain or fullness
☐ sudden weight gain or loss	☐tremors, involuntary movement	☐ diarrhea or constipation
☐ insomnia, sleep disturbances	☐ seizures, loss of consciousness	☐ blood in stool, rectal bleeding
☐ irritability	☐ memory loss	☐ painful or difficult urination
☐ change in voice, hoarseness	☐ mood swings, hallucinations	☐ frequent nighttime urination
☐ vertigo, dizziness, falls	☐ depression, anxiety	☐ urinary incontinence
☐ rashes, skin changes	☐ chest pain or heaviness	☐ pain during intercourse
☐ joint pain, redness, swelling	☐ palpitations	☐ bleeding gums/nose, bruising
☐ increased hair growth	☐ leg pain during activity	☐ fruity breath or body odor
☐ changes in nail beds	☐ discolored or painful feet	☐ temperature intolerance
☐ muscle pain	☐ swelling in ankles or feet	☐ absent perspiration
☐ muscle weakness, atrophy	☐ recent ↑/↓ in blood pressure	☐ night sweats
☐ abnormal reflexes	☐ positional blood pressure changes	☐ intense bone pain at night
☐ numbness, tingling *anywhere*	☐ cough with sputum	☐ change in sense of taste/smell
☐ sharp, radiating pain *anywhere*	☐ shortness of breath	☐ unusual skin lesion or lump
☐ throbbing pain *anywhere*	☐ breathing pain	☐ unusual discharge *anywhere*

If you have indicated any of the above, please explain further -

What is the purpose of your visit today?

Do you have specific questions about your health or healthcare that you would like me to address?

What are your expectations for this assessment and treatment?

Thank you for taking this time to share your journey with me!

Location -

Kimberley Clinic ~ Little Red House, 850 Wallinger Avenue
Vancouver Clinic ~ Pacific Central Station, 1150 Station Street

Fees -

90 minute Comprehensive Initial Examination and Treatment ~ $150
60 minute Treatment ~ $130
I accept Visa, MasterCard, Debit, Cash or Cheque (*Cash or Cheque only at the Vancouver Clinic*)

Cancellation Policy -

I appreciate you have a busy schedule with other commitments to attend. I will do my best to be punctual with our sessions together, and provide adequate notice of any changes. In return, I ask for the same respect. ***Please provide a minimum of 24 hours notice for appointments you cannot attend***. The ***full price*** of the treatment will incur with each appointment missed without adequate notice.

Appointment -

Please remember to bring this form to your appointment so we can review it together. If you have any laboratory or radiology reports, please bring them with you as well. Wearing shorts or yoga pants, and a comfortable t-shirt will assist greatly in the evaluation and treatment - there are places to change at the office.

I look forward to meeting you soon!

Teara

Integrated Balance