

CONFIDENTIAL MEDICAL CASE HISTORY FORM

Name: _____

Phone #: (home) _____ (work or cell) _____ Phone number for Messages: _____

Care Card #: _____ G1 V2 Birth Date: (m)____ (d)____ (y)_____

Address: _____ Postal Code: _____

May the clinic contact you by mail? Yes No

Occupation: _____ Referring Doctor: _____ Billing #: _____

How did you hear about our clinic? _____

ICBC or WCB Claim: Yes No Claim #: _____ Date of Accident: _____

Adjuster's Name: _____ Phone #: _____

Adjuster's Address: _____ Fax #: _____

Lawyer's Name: _____ Phone #: _____

Major Complaint: _____

What makes condition worse? _____ better? _____

Have you had this condition in the past? Yes No. If yes, was it resolved? Yes No

Medications you are presently taking: _____

Surgeries, major injuries or accidents you have had: _____

Stress level: None Slight Moderate Severe Physical activity: None Low Moderate High.

Are you also seeing: Chiropractor Physiotherapist Naturopath Other _____

Please check any of the following conditions that apply to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Osteo/Rheumatoid Arthritis | <input type="checkbox"/> Fractures/Dislocations |
| <input type="checkbox"/> Stroke (CVA) | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Menstrual Problems |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Spinal Injury | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Respiratory Conditions | <input type="checkbox"/> Loss of Sensation/Tingling | <input type="checkbox"/> Contagious Condition |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures | <input type="checkbox"/> Headaches (recurrent) |
| <input type="checkbox"/> Tumours/Cysts | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Backaches |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Digestive Disorder | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Pregnancy | _____ |

I agree to pay for any appointments I miss barring emergencies.

By my signature below, I authorize the collection, use and disclosure of personal information, as defined in the *Personal Information and Protection Act (PIPA)*, required for treatment and/or any related administrative purpose. I understand that all my personal information is confidential, and must be treated in accordance with PIPA.

Signature: _____ Date: _____