BACKS IN ACTION
WELLNESS CENTRE

#203- 1750 East 10th Avenue
Vancouver BC V5N 5K4
(604) 876-9977

Confidential Patient History Form

Today's Date:_____ **Age:**___ **Care Card #:**_____

Name:_____ **DOB:**_____ **Shoe Size:** _____ **Weight:**_____
MM/DD/YYYY

Address:_____ **City:**_____ **Postal Code:**_____

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

Email:_____ **Occupation:**_____ **Gender:** ____M ____F

Emergency Contact:_____ **Phone Number:**_____ **Relation:** _____

Physician:_____ **Phone Number:**_____

Extended Health Provider:_____ **Plan #:**_____

ID #: _____

Are you submitting a claim to ICBC/WorkSafeBC? ☐ Yes ☐ No

Claim # (specific to this injury): _____ **Adjusters Name:** _____

Date of Injury/Accident: _____ **Adjusters Phone #:** _____

Treatment you're seeking?

☐ Chiropractic ☐ Custom Orthotics ☐ Compression Hosiery
☐ Naturopathy ☐ Massage Therapy ☐ Acupuncture

Describe your current condition & symptoms

_____
_____
_____
_____
_____

How long have you had this condition?

_____

How did it start?

_____

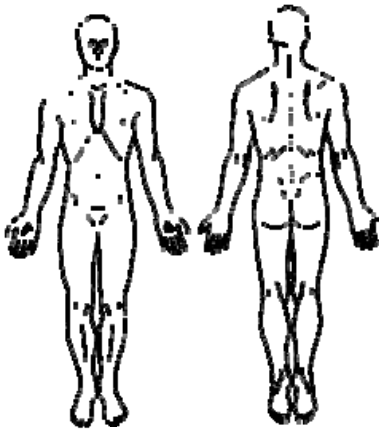
What aggravates it?

_____

What relieves it?

_____

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:



Aching ○ ○ ○
Shooting → →→
Throbbing X X X
Burning # # #
Numbness ≈ ≈ ≈
Tingling Δ Δ Δ

Please list all medications and/or supplements currently being taken:

_____

Known Allergies: (Including medications, food, seasonal, oils and lotions, etc)

_____

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Please list any illnesses or conditions that run in your immediate family:

_____

Have you even been hospitalized, had any major accidents, illness or surgeries: (if so, please describe)

_____
_____
_____

Other Therapy/Treatment: (past or present, Please write name of physician and phone number)

_____
_____
_____

Please indicate if any of the following apply to you? (P= Past, C=Current)

___ AIDS/HIV	___ Allergies	___ Anemia	___ Arthritis
___ Asthma	___ Bone Fracture	___ Bladder Dysfunction	___ Bleeding Disorder
___ Blood Pressure (High/Low)	___ Cancer	___ Cholesterol	___ Deafness
___ Diabetes	___ Digestive Condition	___ Dizziness or Fainting	___ Eating Disorder
___ Epilepsy or other seizures	___ Fatigue	___ Headaches or Migraines	___ Head Injury
___ Heartburn or Indigestion	___ Heart Attack	___ Hepatitis	___ Implants
___ Irritable Bowel or Colitis	___ Joint Dislocation	___ Kidney Disease	___ Liver Dysfunction
___ Lung Disease	___ Menopause	___ Nausea	___ Numbness or Pain
___ Osteoporosis	___ Pacemaker	___ Recurrent Cold or Flu	___ Sinusitis
___ Sleeping Disorder	___ Stroke or Aneurysm	___ Skin Condition	___ Skin Ailments
___ Spinal Injury	___ Transplant	___ Varicose Veins	___ Visual

Please circle the answer closest to how you presently feel: (1= Poor, 5=Excellent)

Quality of Sleep	1	2	3	4	5	**Hours of sleep per night**	__
Eating Habits	1	2	3	4	5	**Number of meals you eat per day**	__
Exercise Habits	1	2	3	4	5	**Number of times you exercise per week**	__
Alcohol	Yes	No	Occasionally			**Smoker** Yes No Occasionally	

Have you had or do you currently own orthotics? ☐ Yes ☐ No

How did you hear about our clinic? _____

What are your expectations from your care at this clinic? _____

_____

I am interested in a 10min consultation with a: (Check all that Apply)

☐ Chiropractor ☐ Massage Therapist ☐ Naturopathic Doctor

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Informed Consent

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment. There are some risks that may be associated with treatment, in particular you should note:

a) While rare, some patients have experienced rib fractures or muscle and ligament strains following treatment;

b) There have been reported cases of injury to a vertebral artery following cervical spinal manipulation. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairments, and have on rare occasion resulted in serious injury. The possibility of such injuries resulting from cervical spinal manipulation is extremely remote;

c) There have been rare reported cases of disc injuries following cervical and lumbar spinal adjustment, although no scientific study has ever demonstrated such injuries are caused by spinal adjustment (chiropractor), soft tissue manipulation or treatment.

Chiropractic treatment, including spinal adjustment, and osseous and soft tissue manipulation have been the subject of government reports and multi-disciplinary studies, conducted over many years and have been demonstrated to be highly effective treatment for spinal conditions . These include but are not limited to general pain and loss of mobility, headaches and other similar symptoms. Chiropractic and massage therapy treatments are substantially lower risk than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

I acknowledge I have discussed, or have opportunity to discuss, with my chiropractor or massage therapist the nature and purpose of chiropractic or massage treatment in general and my treatment in particular (including spinal adjustments) as well as the contents of this consent.

I, _____ intend this consent to apply to all my present and future care
Patient Name

with _____ dated this _____ day of _____ 20 ___
Practitioner's Name Month

_____ _____
Patient Signature or Legal Guardian Signature Witness Signature

In Consideration of other Patients & the Practitioner, please provide 24 hours notice if you are unable to make an appointment. For Chiropractic, any Late Cancellations or No Shows will be subject to a 30.00 Cancellation Fee. For Massage Therapy any Late Cancellations or No Shows will be subject to the full appointment fee.

Assignment of Benefits

I, _____ authorize the Medical Services Plan to pay _____
Beneficiary Practitioner

directly for all reimbursements for benefits payable to me under the medical and Health Care Services Regulation for care provided to me by said Practitioner.