westwood
TOTAL HEALTH

Confidential Patient Information

Personal Information

Name:_____ Date:_____
Address:_____
City:_____Postal Code:_____
Birthdate:_____ Age:_____ Marital Status: S M D W C/L E Spouse:_____
#of Children:_____ Children Ages:_____ Email:_____
Phone #: Home:_____ Work:_____
Cell:_____
Occupation:_____ Employer:_____
Who may we thank for referring you to our office?:_____

Chiropractic History

Have you been to a Chiropractor before:Yes/No Name of Previous Chiropractor:_____
When:_____ How long did you receive care:_____ Were X-Rays taken:_____

Motor Vehicle Accidents

Have you been in a car accident in the last 2 years:_____ Accident Date:_____
Do you have an open claim with ICBC for this accident:_____ Claim number:_____

Goals for Care *(Circle reasons that apply)*

- Symptom Relief
- Correcting the cause of my problem
- 100% optimal health and healing

Major Health Concern

CONDITION 1

Please describe your chief health concern:_____
On a scale of 1-10 (10 being worst), how bad is the problem: ____/10
When did the problem start:_____ How:_____
Is it: Getting Better? Getting Worse? Staying the Same? On/Off?
How would you describe the problem:_____
What activities aggravate the problem (Please Describe):_____
What relieves your symptoms, if any:_____

Spinal History

Spinal Subluxations (spinal misalignment) can be cause by traumas such as motor vehicle accidents, falls, heavy lifts, etc. Please list below any falls or accidents that may apply (with approximate dates):

_____
_____
*Please list any surgeries(with approximate dates)*_____
*Are you taking medication? Yes No Please list all medications:*_____
_____

Health Conditions

Please CIRCLE each of the diseases or conditions that you have now or have had in the past. While some conditions may seem unrelated to the purpose of this appointment, they can affect diagnosis, and care plan.

General
- Dizziness
- Fatigue
- Headache
- Loss of Sleep
- Loss of Weight
- Anxiety/Depression
- Numbness
- Cancer
- Diabetes
- Thyroid Problems
- Epilepsy
- Hyperactivity
- Seizures

Genito-Urinary
- Bed Wetting
- Painful Urination
- Prostate Trouble
- Blood in Urine
- Venereal Disease
- Bladder Infection
- Frequent Urination

Muscle and Joint
- Arthritis
- Hernia
- Low Back Pain
- Neck Pain
- Pain Between Shoulders

Numbness or pain in:
  - Shoulders
  - Upper Arms
  - Hands
  - Legs
  - Feet
  - knees
  - Hips

- Poor Posture
- Swollen Joints
- Gout
- Restless Legs
- Polio

Respiratory
- Asthma
- Chronic Cough
- Irregular Breathing
- Wheezing
- Emphysema

Gastrointestinal
- Constipation
- Diarrhea
- Digestive Dysfunction
- Gall Bladder Trouble
- Hemorrhoids
- Liver Trouble
- Ulcers
- IBS
- Crohn's
- Acid Reflux
- Bloating
- Food Sensitivity

Eyes, Ears, Nose, Throat
- Allergies (seasonal)
- Frequent Colds
- Crossed Eyes
- Deafness
- Ear Infections
- Ringing in Ears
- Eye Pain
- Vision Problems
- Nasal Obstruction

Cardio Vascular
- High Blood Pressure
- Low Blood Pressure
- Poor Circulation
- Irregular Heart Beat
- Ankle Swelling
- Anemia
- Arteriosclerosis
- Stroke

Women Only
- Menstrual Cramps
- Excessive Menstruation
- Irregular Cycle
- Hot Flashes

Could you be pregnant?

YES
NO
MAYBE

Date of Last Period: _____

CONDITION 2 (if applicable)

Please describe health concern:_____

On a scale of 1-10 (10 being worst), how bad is the problem: ____/10

When did the problem start:_____ How:_____

Is it: Getting Better? Getting Worse? Staying the Same? On/Off?

How would you describe the problem:_____

What activities aggravate the problem (Please Describe):_____

What relieves your symptoms, if any:_____

CONDITION 3 (if applicable)

Please describe health concern:_____

On a scale of 1-10 (10 being worst), how bad is the problem: ____/10

When did the problem start:_____ How:_____

Is it: Getting Better? Getting Worse? Staying the Same? On/Off?

How would you describe the problem:_____

What activities aggravate the problem (Please Describe):_____

What relieves your symptoms, if any:_____

I certify that the information contained in this form is correct to the best of my knowledge

_____ _____

Patient Signature Date

I give Westwood Total Health permission to send me emails pertaining to my care ie: appointment remainders, billing information, upcoming workshops, and valuable information regarding my care. Should I choose, for any purposes, to unsubscribe from said emails, I will reply with UNSUBSCRIBE in the subject box *(please circle yes or no)*

YES ***NO***