Burrard Chiropractic & Foot Orthotics

Dr. Farokh Zavosh © BURRARD CHIROPRACTIC 2010

CONFIDENTIAL PATIENT INFORMATION

Date:__________ BC Health Card #:_____/_____/_____

Name:____

(Last) (First) (Middle)

Address:______________________________________

(Street)

____

(City/Province) (Postal Code)

Home Phone #:______________Cell # :______________

Email:____

Date of Birth(M/D/Y):________________ Age:_______

Family Doctor:________________ Phone #:__________

Sex: ( )Female ( )Male Occupation:____________________

Employer's Name:______________ Work Phone #:____________

Marital Status: ( )Single ( )Married ( )Separated ( )Divorced ( )Widowed

Number of Children:____ Name of Spouse:________________

Emergency Contact: Name_____________ Phone #___________

How did you hear about us: ( )Website ( )Yellow Pages ( )Walk-in ( )Referred by:________________ Others:______________

Prior Chiropractic Care:____ Doctor's Name:________________

X-ray taken?_____ Date of X-ray:______________________

Y	N	
( )	( )	Is this injury/condition work related
( )	( )	Is this injury/condition due to motor vehicle accident?
( )	( )	Do you anticipate litigation for this injury/condition?
( )	( )	Are you currently involved in any litigation for any other injury/condition other than this current injury?
( )	( )	Are you currently under care for an occupational injury other that this current injury?

Past History:	Y	N	Comments:
As a child, were you immunized?	( )	( )	____________
Did you have any serious childhood illnesses/trauma?	( )	( )	____________
Have you had any surgeries?	( )	( )	____________
Have you had any past injuries, including fractures?	( )	( )	____________

Family History:
Is there any history of ( )Arthritis, ( )High/Low Blood Pressure, ( )Heart Disease, ( )Stroke, ( )Cancer, ( )Diabetes, ( )Fatalities, and /or ( )Genetic Disorder in your family.

Occupational History:
Indicate your job activities at your work place, and years involved:

Purpose of this appointment (Please be specific):...........................

Additional health complaint (If any):...........................

When did your condition/pain start?...........................

What caused your pain?(If you know)...........................

Pain is ( )Sharp ( )Dull ( )Constant ( )Pins and Needles ( )Stiffness ( )Numbing ( )Other

Does the pain travel? ( )No ( )Yes If yes, Describe the path and location...........................

What activities aggravate your condition/pain?...........................

What activities lessen your condition/pain?...........................

Is this condition interfering with your work or daily activities?...........................

Is this condition interfering with your sleep?...........................

Is your condition getting progressively ( )Worse ( )Better ( )Same ( )Comes and Goes

Is your condition worse during certain times of the day?( )A.M. ( )P.M.

Please Turn Over →