Ali R. Akhavan B.Sc. (Kin.), D.C.
Doctor of Chiropractic

CONFIDENTIAL PATIENT HEALTH PROFILE

Last Name _____ First Name _____

Address _____ City _____ Province _____ Postal Code _____

Home Phone _____ Cell Phone _____ Email _____ Care Card # _____

Employer _____ Occupation _____ Work Phone _____

How young are you? _____ Date of Birth (D/M/Y) _____ Family Doctor _____

Martial Status O Single O Married O Divorced O Separated O Widowed O Other: _____

In event of emergency, who should we contact? _____ Relation: _____ Contact Phone: _____

How did you discover our office? _____ If referred, whom may we thank for referring you? _____

ICBC/WCB Claim #: _____ Adjustor: _____ Phone: _____

HEALTH CONCERNS

What health concern has brought you to our office? _____

Please describe the pain & its location: _____

When did this condition begin? Is this condition getting worse? O Yes O No O Comes and goes O Constant

Please grade the severity of your pain on scale of O (No Pain) to 10 (worst pain imaginable) _____

What do you think caused this condition? _____

Is this condition interfering with your (Please Circle): Work Sleep Daily Routine Leisure Activities

If so, please explain: _____

Have you had this or similar condition in the past? O Yes O No

If so, please explain: _____

What treatment have you already received for your condition? _____

O Medication O Physiotherapy O Massage therapy O Acupuncture O Surgery O Others: _____

Please list any medications/supplements you are currently taking: _____

Have you seen a Doctor of Chiropractic in the past? O Yes O No

Date of last visit: _____ Reason for the visit: _____

HEALTH CONCERNS *(continued)*

Have you ever injured your spine (neck, head, back,hips)? O Yes O No

If yes, please explain:

Have you ever had a Work or Motor Vehicle Accident related injury? O Yes O No

If yes, please explain:

Have you had an X-Ray, CT Scan, or MRI Scan of your injury or spine? O Yes O No

If yes, what was discovered on those?

Have you had any surgeries? O Yes O No

If yes, please explain:

Are there any health conditions that run in your family? O Yes O No

If yes, please explain:

STRESS HISTORY

Please rate the following on a 0-10 point scale: 0=Low ,10=high

Physical Stress level (Posture, Sitting, Standing, Lifting, Twisting) /10

Chemical Stress level (Diet, Smoking, Alcohol, Caffeine, Cigarettes) /10

Emotional Stress Level (Relationships, Deadlines, Loss of Loved ones, Responsibilities) /10

HEALTH HISTORY

Circle "Yes" or "No" to indicate if you have experienced any of the following:

Alcoholism	Yes	No	Fever (prolonged)	Yes	No	Multiple Sclerosis	Yes	No
Thyroid Problems	Yes	No	AIDS/HIV	Yes	No	Frequent Colds	Yes	No
Numbness	Yes	No	Tiredness	Yes	No	Allergy Shots	Yes	No
Glaucoma	Yes	No	Osteoarthritis	Yes	No	TMJ (Jaw)	Yes	No
Anemia	Yes	No	Gout	Yes	No	Osteoporosis	Yes	No
Tremors	Yes	No	Arthritis	Yes	No	Hearing Loss	Yes	No
Pinched Nerve	Yes	No	Tuberculosis	Yes	No	Asthma	Yes	No
Heart Attack	Yes	No	Pneumonia	Yes	No	Tumors, Growths	Yes	No
Bronchitis	Yes	No	Hernia	Yes	No	Prostate Problem	Yes	No
Ulcers	Yes	No	Cancer	Yes	No	Herniated Disc	Yes	No
Psychiatric Care	Yes	No	Whooping Cough	Yes	No	Chemical Dependency	Yes	No
High Blood Pressure	Yes	No	Rheumatic Fever	Yes	No	Vision Problems	Yes	No
Diabetes	Yes	No	High Cholesterol	Yes	No	Rheumatoid Arthritis	Yes	No
Difficulty Breathing	Yes	No	Infertility	Yes	No	Ringing in Ears	Yes	No

Women Only

Dizziness	Yes	No	Kidney Disease	Yes	No	Sinus Infections	Yes	No
Hysterectomy	Yes	No	Emphysema	Yes	No	Liver Disease	Yes	No
STD's	Yes	No	Miscarriage	Yes	No	Epilepsy	Yes	No
Low Back Pain	Yes	No	Stroke	Yes	No	Menopause	Yes	No
Headaches	Yes	No	Mid Back Pain	Yes	No	Premenstrual Syndrome	Yes	No
Migraines	Yes	No	Irregular Menses	Yes	No	Cramps	Yes	No
Breast Problems	Yes	No						

Signature:

We look forward to partnering with you to regain and maintain your health