Coastal Roots Health

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Victoria B.C. V8T 5K2
778-432-4412

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Sooke B.C. V9Z 1H5
778-425-4412

CHIROPRACTIC INITIAL VISIT CONTACT INFORMATION

Name: _____ Today's Date: _____

BC Care Card #: _____ Date of Birth (MM/DD/YYYY): ___/____/_____

Mailing Address: _____ Postal Code: _____

Home phone: _____ Cell phone: _____

Email: _____ Emergency Contact: _____

Occupation: _____ Work phone: _____

How did you hear of our office? _____

MD Name: _____ Phone: _____

CURRENT HEALTH STATUS

ICBC/WCB: ☐Yes ☐No Claim #_____ Date of Accident (MM/DD/YYYY): ___/____/_____

Please list your main health concern:_____

When did this start? _____ What do you think caused this? _____

Have you had this problem before? ☐Yes ☐No When?_____

What makes it worse? _____ What makes it better? _____

How is this health issue affecting your everyday life? _____

Please list any other health concerns:_____

Please circle if you have seen another Chiropractor, Massage Therapist, Acupuncturist, Physiotherapist, Podiatrist or Naturopath within the year.

Program of care ☐Wellness Care ☐Pain Relief ☐Corrective Care

Have you ever been in a motor vehicle accident? ☐Yes ☐No

Date: _____ Injuries sustained _____

Date: _____ Injuries sustained _____

Have you had any other personal injuries or accidents? ☐Yes ☐No

Date: _____ Treatment _____

Prior surgeries & dates _____

_____

Present medications/supplement you are taking _____

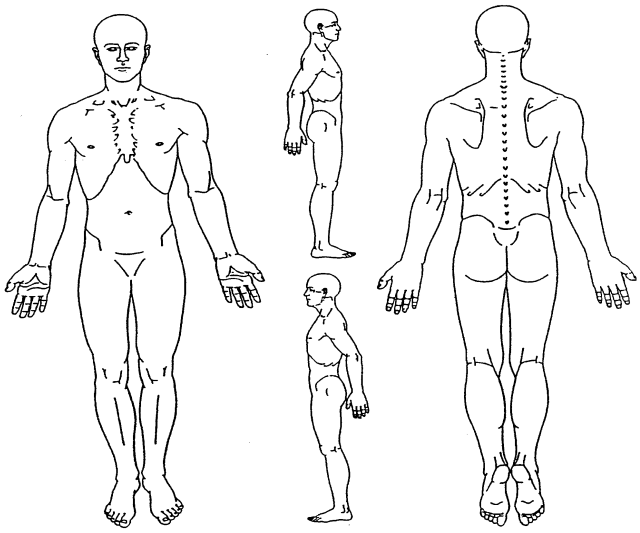
Females only: Are you pregnant? ☐Yes ☐No ☐Unsure # of Children_____

Do you suffer from ☐Hot flashes ☐Cramps ☐Irregular periods ☐PMS ☐Infertility Dysfunction

Check any of the following symptoms you may be experiencing now, or have experienced recently:

☐Tension headache
☐Migraine headache
☐Neck pain
☐Neck stiffness
☐Swollen ankles
☐Shooting chest pain
☐Shortness of breath
☐Numbness of face
☐Shooting pain down arms
☐Numbness in hands
☐Cold hands/feet
☐Decreased neck range of motion
☐Upper back tension
☐Muscle spasm
☐Shoulder tightness
☐Rotator cuff pain
☐Mid back pain
☐Foot numbness
☐Knee problems
☐Grinding in neck
☐Poor Memory
☐Swollen joints
☐Whiplash
☐Low back pain
☐Leg pain
☐Sciatica
☐Leg tingling
☐Leg weakness
☐Fatigue
☐Difficulty Driving
☐Ankle problems
☐Painful joints
☐Pinched nerves
☐Difficulty Lifting/Bending

Please indicate areas of concern:



HEALTH ENHANCEMENT PROGRAM

What activities do you participate in?_____

What sports do you currently play?_____

What is your current level of stress? ☐Low ☐Moderate ☐High

How would you like to improve your overall quality of life other than pain relief?_____

_____