Columbia Integrated
Health Centre

GENERAL HEALTH HISTORY QUESTIONAIRE

□ CHIROPRACTIC □ MASSAGE THERAPY □ PHYSIOTHERAPY

Name:_____ Date:_____

Date of Birth:_____Carecard No:_____

Address:_____City:_____

PostalCode:_____Email Address:_____

Home Phone: _____Cell:_____Work:_____

Occupation:_____

Do you wish to receive appointment reminders via: Text □ Email □ Both □

If you selected yes to Text appointment reminders, who is your cell phone provider?
(eg: Fido, Telus, Rogers, Bell)_____

Emergency Contact Person:_____Phone:_____

Family Doctor:_____Phone:_____

How did you hear about the clinic?_____

Are you coming in today regarding an ICBC or WCB claim? Yes □ No □
If you selected yes, please complete this section:

ICBC □ WCB □ Claim No:_____ Date of Injury/MVA:_____

Adjuster/Case Manager:_____Phone No:_____

Lawyers Name:_____Phone No:_____

What is the *main problem* you would like us to address today?

_____

_____

_____

When did you first notice any symptoms?_____

Are your symptoms currently: Getting Better □ Getting Worse □ Staying the Same □

Have you ever experienced these symptoms before?

_____

What is your current stress level? □ Low □ Moderate □ High

Is your present condition the result of a single traumatic event? If so, what happened?

_____

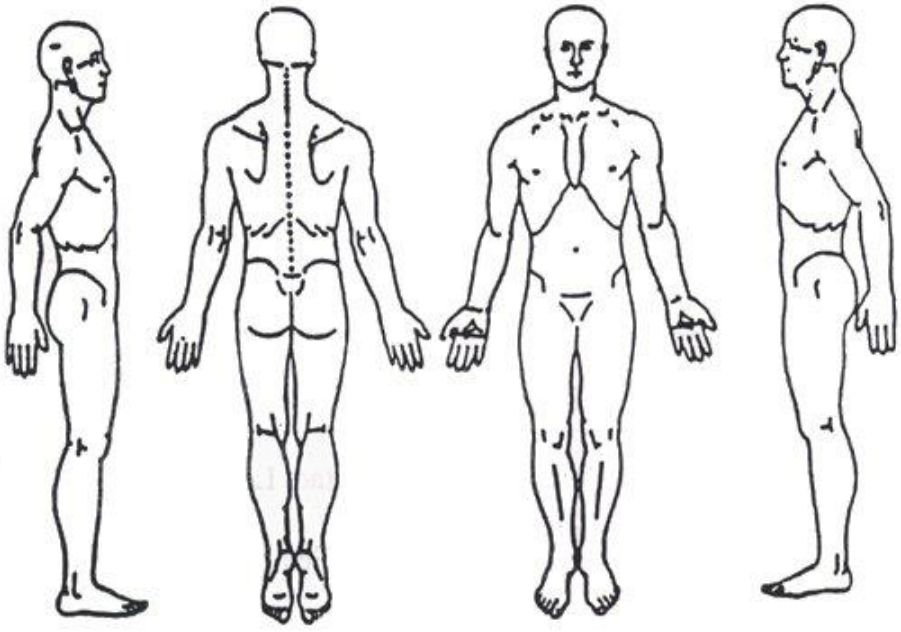
_____

What other types of treatment, if any, have you received for this condition? Did it help?

_____

_____

Please mark the area(s) on the diagram where you feel the described sensations:



Sharp Pain: XXXX Dull/Aching Pain:0000 Numbness/Tingling: *IIIIII* Shooting Pain: >>>>

What aggravates these symptoms?

□ standing □ sitting □ lying down □ walking □ running □ jumping

□ bending □ twisting □ lifting □ coughing □ sneezing □ bowel movements

□ getting up from a chair □ other_____

What relieves these symptoms?

□ rest □ ice □heat □ stretching □ exercising □ medication □ other_____

Medical History:

Have you RECENTLY noted any of the following? (check all that apply)

□ fatigue	□ numbness/tingling	□ constipation
□fever/chills/sweats	□ muscle weakness	□ diarrhea
□nausea/vomiting	□ dizziness/light-headedness	□ shortness of breath
□ weight gain/loss	□heartburn/indigestion	□fainting
□ falls	□difficulty swallowing	□cough
□headaches	□changes in bowel or bladder function	

Have you EVER been diagnosed with any of the following conditions?(check all that apply)

□ cancer	□ depression	□ thyroid issues
□ heart problems	□ lung problems	□ diabetes
□ tuberculosis	□ osteoporosis	□ high blood pressure
□ asthma	□ multiple sclerosis	□ circulation problems
□ rheumatoid arthritis	□ epilepsy	□ blood cots
□ eye problems/infection	□ bladder/urinary tract infection	□ stroke
□ ulcers	□ anemia	□ liver problems
□ kidney problem	□ bone or joint infections	□ bone fracture
□ Hepatitis	□ HIV	□ drug/alcoholism
□ pneumonia	□ pelvic inflammatory disease	

Has anyone in your immediate family been diagnosed with any of the following?:

□ cancer	□ diabetes	□ tuberculosis	□ heart problems
□ stroke	□ thyroid issues	□ high blood pressure	□ depression

Have you ever had any broken bones? if yes, which ones?_____

Have you ever had any surgery? If yes, please describe:

_____

_____

Please list any medications you are currently taking, including vitamins and supplements:

_____

_____

Do you smoke cigarettes? if yes, approximately how many per day?_____
Do you drink alcohol? if yes, approximately how much per week?_____

If there is any other information regarding your present condition that you think my help us, please mention it here:

_____

_____

To be completed by patients eligible for MSP Premium Assistance.
*(*Please ask the front desk if you need further explanation of MSP benefits)*

ASSIGNMENT OF MEDICAL SERVICES PLAN BENEFITS TO COLUMBIA INTEGRATED HEALTH CENTRE

I authorize the Medical Services Plan to pay *COLUMBIA INTEGRATED HEALTH CENTRE* 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.

I make this assignment in full knowledge of the amount that I will be personally responsible for and the amount that is reimbursable by the Medical Services Plan, which will be directed to *COLUMBIA INTEGRATED HEALTH CENTRE* and be applied against any outstanding monies I owe for services provided.

This form allows your practitioner to receive your MSP reimbursement directly for services that are MSP benefits. Your practitioner, by law, must advise you of their full fee and what portion will be reimbursed by MSP. By agreement, your practitioner may not charge you the portion reimbursable by MSP.

I understand that any MSP benefits over and above the 10 treatments allotted per year will be my responsibility to pay.

Care Card Number (PHN):_____

Full Name (as it appears on your Care Card):

_____

Signature: _____

Date: _____

Cancellation Policy:

In consideration of other patients and my therapist, I understand that a minimum of 24 hours notice is required to change or cancel my appointment. **I am aware that is my responsibility to pay 50% of the treatment fee in the case of late cancellations or missed appointments. Cancellation fees are payable before rebooking another appointment.**

By signing below you understand that the information is true to the best of your knowledge and understand and agree to our cancellation policy:

Patient Name_____Signature_____

Date:_____ Witness:_____