



GENERAL HEALTH HISTORY QUESTIONNAIRE

CHIROPRACTIC **MASSAGE THERAPY** **PHYSIOTHERAPY**

Name: _____ Date: _____

Date of Birth: _____ Carecard No: _____

Address: _____ City: _____

Postal Code: _____ 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

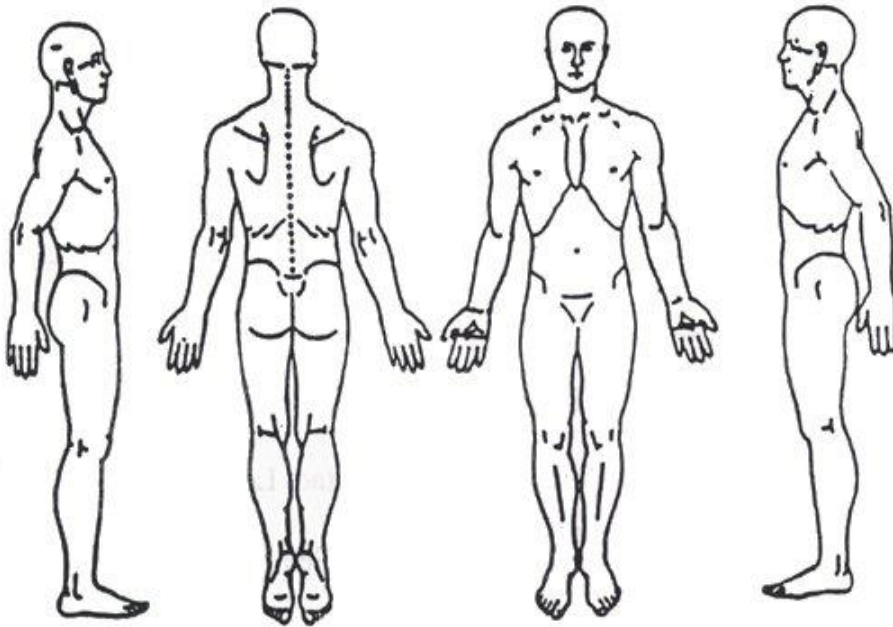
Have you ever experienced these symptoms before?

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: IIIII 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)

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

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

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

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

- | | | | |
|---------------------------------|---|--|---|
| <input type="checkbox"/> cancer | <input type="checkbox"/> diabetes | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> heart problems |
| <input type="checkbox"/> stroke | <input type="checkbox"/> thyroid issues | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> 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 it 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: _____