Ocean Wellness Clinic
#200 - 1401 Lonsdale Ave.
North Vancouver, BC, V7M 2H9

Patient Information

Patient Name: _____ Today's Date: _____

Mailing Address: _____ City: _____ Postal: _____

Mobile: _____ Home: _____ Email: _____

Age: _____ Birth Date: _____ Occupation: _____

Primary Physician: _____ City: _____

How did you hear about us? _____

Do you have extended healthcare coverage? ☐ No ☐ Yes Care Card #: _____

Chief Complaint

Why are you seeing the doctor today?
What is the injured area? _____

Current problem is a result of: ☐ Car Accident ☐ Work accident ☐ Sports Injury ☐ Other

How long has this condition existed? _____

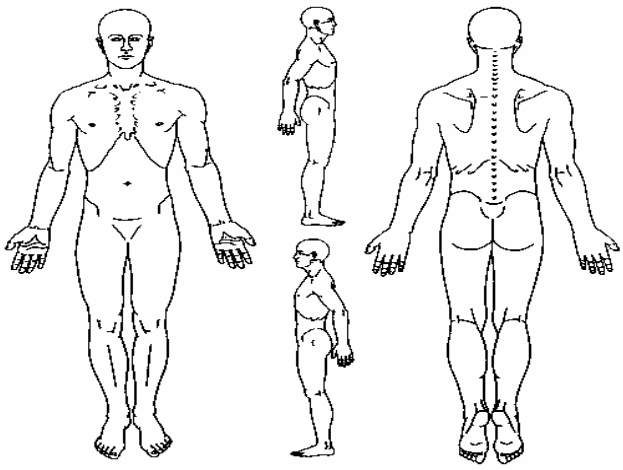
What makes it better? _____

What makes it worse? _____

Is the condition improving or getting worse? _____

Please indicate on the figures below the location of your complaint using shading and numbers

1. Dull Achy
2. Sharp Stabbing
3. Shooting
4. Burning
5. Numbness
6. Pins and Needles
7. Loss of feeling
8. Weakness



Doctor's Notes (DO NOT write below)

Treatments & Testing

What medications have you tried for this problem? _____

Physical Therapy? ☐ No ☐ Yes When? _____ Where? _____

X-rays / MRI / CT? ☐ No ☐ Yes When? _____ Where? _____

Any Positive Findings: _____ Have you seen a Chiropractor before: No ☐ Yes ☐

If Yes When:_____ Dr's Name: _____

Past & Current / Social / Family Health History

Please circle any of the following conditions that run in your family history:

Arthritis Heart Disease Stroke High/Low Blood Pressure Cancer Diabetes Other: _____

Motor Vehicle Accidents (please indicate approximate dates):

Injuries - Surgeries – Concussions	Year(s)	Complications

Do any of the following apply to you?

____ High or low blood pressure (circle)
____ Heart condition
____ Headache/migraine
____ Contagious condition
____ Unexplained fatigue
____ Digestive problems
____ Respiratory condition
____ Circulatory problem
____ Sprains/strains/dislocations

____ Arthritis
____ Kidney condition
____ Pregnancy
____ Head injury
____ Spinal injury
____ Recent surgery
____ Disc/joint/spinal
____ PMS
____ Sleep disturbance

____ Epilepsy
____ Stroke
____ Diabetes
____ Cancer
____ Allergies
____ Infections
____ Fractures
____ Fainting
____ Jaw pain

Please Indicate the Following:

Water Intake (cups/day) _____
Smoker: ____ No ____ Yes

Exercise (times/week) _____
Alcohol (times/week) _____

Sleep (hrs/night) _____
Ave. drinks/session _____

Your Medications (Reasons for taking): _____

Allergies: ☐ No known medical allergies ☐ Latex/Tape ☐ Other: _____

Women Only

Are you pregnant? ____ No ____ Yes ____ Maybe
When was your last Menstrual Cycle? (Date of onset): _____

Please check any of the following if they are relevant to your medical history:

____ Cramps or Backache ____ Excessive Menstrual Flow ____ Irregular Cycle
____ Hot Flashes ____ Painful Menstrual Flow ____ Menopausal Symptoms