HEALTH QUEST
Confidential Medical History

Date_____ Care Card Number _____

Name_____ Birthdate mm/day/yr_____

Address_____ Postal Code_____

Occupation_____ Place of employment_____

Phone# (Home)_____(Work)_____

Email: _____

Have you had previous chiropractic care? Yes / no How long ago?_____

With whom? Dr._____

Who referred you to our office? _____

Are you currently seeing any other medical practitioners for this condition? (Who and when) _____

Who is your current Medical doctor: Dr. _____ city: _____

Have you had X-rays before: Which part of the body: _____

Date of X-rays:_____ Location of X-ray facility: _____

Is this complaint the result of a car accident (ICBC)? Date of accident: _____

Claim #_____ Adjuster: _____

Is this a work related injury (WCB)? Date of initial injury: _____

Claim # _____ Adjuster: _____

What is your main complaint? _____

Onset: how did this happen? _____

When did it happen? _____

When is the pain worse? (morning\ in activity\ evening)_____

Is there any positions or activities that make it worse? _____

Have you done/ found anything that makes it feel better? _____

Do you have a secondary complaint? _____

Vitals-

Height:_____ ft/ cm Weight: _____lbs/ Kg

Report any weight changes in the last 12 months? Gained: _____lbs or lost: ____lbs

Do you have orthotics? When were they made _____

Who made them for you? _____

Medical conditions- please check all that you have or have had:

( ) diabetes	( ) migraines/headaches	( ) whiplash
( ) asthma	( ) fibromyalgia	( )numbness/tingling (
) allergies	( ) chronic fatigue	( ) pregnancy
( ) heart conditions	( ) osteoporosis	( ) neck / back aches
( ) skin conditions	( ) Blood pressure (high or low)	( ) arthritis
( ) epilepsy or seizure	( ) Anxiety/stress	( ) menstrual cramps

( ) Contagious conditions (eg. Hepatitis or HIV): _____
( ) Cancer Type: _____ when:_____ Treatment: _____
( ) Other:_____

( ) List any inherited diseases in your family (eg. cancer, diabetes, etc) _____
_____
_____

Medications:
(Doctor/patient confidentiality laws protect this document. For your safety please answer honestly.)

( ) Birth Control Pill	( ) Hormone therapy	( ) Tylenol 3's
( ) NSAIDS (Tylenol/ Aspirin, etc)	(estrogen / thyroid)	( ) Marijuana
( ) Tobacco _____ cig/ day	( ) Alcohol ___drinks/ week	( ) Recreational drugs

( ) Pease list any other medication you are taking and what it was prescribed for:

- _____ for _____
- _____ for _____
- _____ for _____
- _____ for _____
- _____ for _____
- _____ for _____

Any other injuries (broken bones, **elective or emergency surgeries**, auto accidents, etc.)- Please include when they occurred:

- _____ when: _____
- _____ when: _____
- _____ when: _____
- _____ when: _____
- _____ when: _____

Exercise/ activity
( ) walk ( ) run ( ) bike ( ) exercise class ( ) gym ( ) swim_____ times per week for _____minutes.