Dr. Paul Chauhan

PATIENT INFORMATION

Name (as on Care Card)_____ Care Card # _____

Address _____ City _____ Postal Code_____

Home Phone _____ Cell Phone _____ Birthdate_____
(mm/dd/yr)

Marital Status S M D W Name of spouse_____ Number of children _____

Employer _____ Work Phone _____

Email Address_____

Have you received Chiropractic care before? Y__N__ Date of last visit _____

Family Doctor _____May we correspond with your MD? ☐ Yes ☐ No

Referred to this clinic by _____

ICBC Claim Y__N__ ICBC Claim # _____ WCB Claim Y__N__ WCB Claim # _____

Purpose of this visit _____

(If this is a well patient exam and you are symptom free, please continue to –Lifestyle)

ONSET: When did this problem start _____How did it start _____

Have you had this pain before?_____

COURSE: Is the problem getting better, worse, or constant _____

Are the attacks becoming more/less frequent _____

PAIN: Describe the pain _____

Is the pain worse in the morning/afternoon/evening _____

Is the pain constant, or comes and goes _____

RADIATION: Does the pain travel anywhere else? Y__N__ Where _____

AGGRAVATING:

What makes the pain feel worse? (circle answer) standing sitting bending lying walking running lifting twisting jumping coughing sneezing rising from chair other _____

RELIEF: What makes it feel better? (circle answer)

rest exercise ice heat stretching medication other _____

LIFESTYLE: What do you do for exercise _____

OTHER: Is there anything going on at the same time? Y__ N __

If yes, please explain _____

MEDICAL BACKGROUND:

What surgeries have you had _____ When _____

Have you broken any bones? Y__ N__ Where _____

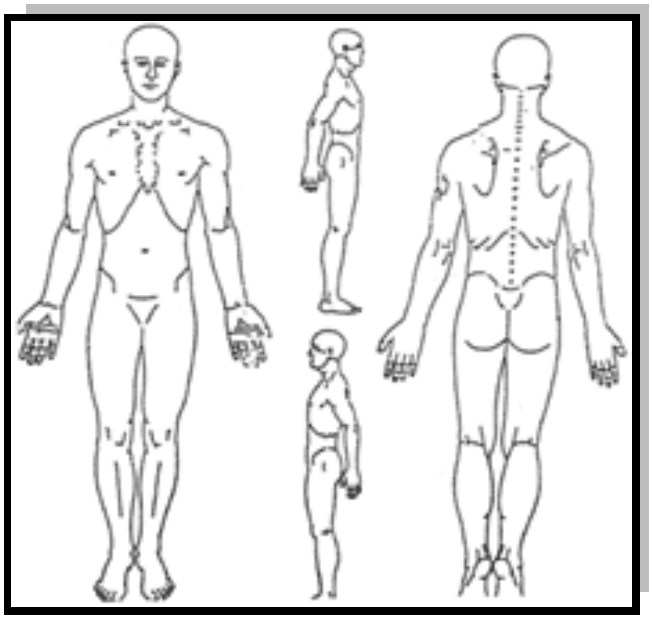
Have you been in any vehicle accidents? Y__ N__ When _____

Have you had any major health problems? (circle answer)

heart cancer diabetes blood pressure arthritis other _____

Are you taking any medication Y__ N__ What _____

Do you smoke or drink regularly _____



Please circle any areas of concern on adjacent figure.

Please check applicable boxes:

Musculoskeletal System
- □ Low back problems
- □ Pain between Shoulders
- □ Neck pain
- □ Arm pain
- □ Leg pain
- □ Swollen joints
- □ Painful joints
- □ Stiff joints
- □ Sore muscles
- □ Weak muscles
- □ Walking Problems
- □ Ruptures of tendons

Genito-Urinary System
- □ Bladder trouble
- □ Excessive urine
- □ Scanty urination
- □ Painful urination
- □ Discoloured urine

Female System
- □ Vaginal discharge
- □ Vaginal Bleeding
- □ Vaginal Pain
- □ Breast Pain
- □ Lumps on breast

GI System
- □ Poor appetite
- □ Excessive hunger
- □ Difficult chewing
- □ Difficult swallowing
- □ Excessive Thirst
- □ Nausea
- □ Abdominal Pain
- □ Diarrhea
- □ Constipation
- □ Black stool
- □ Blood in stool
- □ Hemorrhoids
- □ Liver trouble
- □ Gallbladder
- □ Weight trouble

Nervous System
- □ Numbness
- □ Loss of Feeling
- □ Paralysis
- □ Dizziness
- □ Fainting
- □ Headaches
- □ Muscle Jerking
- □ Convulsions
- □ Forgetfulness
- □ Confusion
- □ Depression

Cardio Vascular
- □ Difficult Breathing
- □ Persistent Cough
- □ Coughing phlegm
- □ Coughing blood
- □ Rapid Heartbeat
- □ Blood Pressure
- □ Heart Problems
- □ Lung Problems
- □ Varicose Veins

Eye, ear, nose and throat
- □ Eye strain
- □ Eye inflammation
- □ Vision problems
- □ Ear Pain
- □ Ear noises
- □ Hearing loss
- □ Ear discharge
- □ Nose pain
- □ Nose bleeding
- □ Nose discharge
- □ Difficult breathing through nose
- □ Sore gums
- □ Dental problems
- □ Sore mouth
- □ Hoarseness
- □ Difficult Speech

☐ Is there anything we missed?: _____

As a result of chiropractic care, I would like to (please check all that apply) ;

- □ Feel better quickly
- □ Have a healthier body by keeping their nervous system healthy
- □ Have a healthier spine
- □ Live a healthier lifestyle