



## Patient History

**Easiest way to find our office:**

Enter Bentall Centre at corner of  
West Pender and Burrard Street.

Go down escalator.

Kilian Chiropractic is straight ahead.

(20 meters)

604.688.0724

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Birth date: (day/month/year) \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Gender: Male or Female

Occupation: \_\_\_\_\_ Spouse: \_\_\_\_\_

How did you hear about the office? \_\_\_\_\_

Do you have extended health care benefits? Yes or No

***If YES, please find out about it before your next visit.***

## History

List all Motor Vehicle Accidents you have had: (dates and severity)

\_\_\_\_\_

List all past impacts, hard falls, sports, concussions, broken bones, etc. (dates and severity)

\_\_\_\_\_

How many hours a day do you spend sitting? \_\_\_\_\_

List type of exercise you do and frequency per week:

\_\_\_\_\_

List all medications you are currently taking:

\_\_\_\_\_

List all major surgeries you have had (include dates):

\_\_\_\_\_

Are you pregnant? Yes or No If so, when is your due date? \_\_\_\_\_

## Current

What is your chief complaint – the reason you came to the office?

\_\_\_\_\_

How long have you been tolerating your main complaint?

\_\_\_\_\_

Have you ever had this problem in the past? Yes or No If so, when? \_\_\_\_\_

Have you seen any other practitioners for this problem? Yes or No

If yes, whom? (circle all that apply)

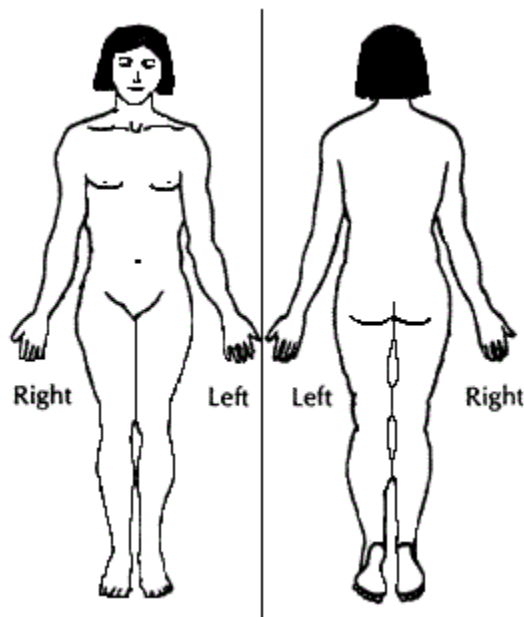
Chiropractor    Massage    Naturopath    Acupuncture    TCM  
MD    Neurologist    Orthopedist    Personal Trainer    Physiotherapy

What makes the problem worse? \_\_\_\_\_

What makes the problem better? \_\_\_\_\_

**On the diagram below, show WHERE you are experiencing all of your present complaints USING the following letters:**

- A: ACHING**
- B: BURNING**
- C: CRAMPING**
- D: DULL**
- G: TIGHT**
- N: NUMBING**
- R: THROBBING**
- S: STIFF**
- T: TINGLING**



Does the pain travelling down your: Arms? Yes or No      Legs? Yes or No

What is the severity of pain on a scale of 1-10 today? \_\_\_\_ / 10      At its worst? \_\_\_\_ / 10

When does your pain occur? (circle one) AM or PM or VARIES or ALL DAY

What specific life activities does it interfere with? (work, sleep, leisure, sleeping, driving, etc)

\_\_\_\_\_

Have you lost time from work because of it? Yes or No    If so, when? \_\_\_\_\_

**Rate your level of commitment to resolving this/these problems (10 being the highest)**

**1      2      3      4      5      6      7      8      9      10**