



407-1200 LONSDALE AVE  
NORTH VANCOUVER, BC V7M 3H6

## PATIENT INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Birthdate (yy/mm/dd) \_\_\_\_\_ Age: \_\_\_\_\_  M  F

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email \_\_\_\_\_ (We will not share or sell your email)

I would like to receive Avita Health's free e-mail newsletter featuring clinic news and health and wellness information (You may unsubscribe at any time)  Yes  No

Is this condition part of an ICBC \_\_\_\_\_  Yes  No

Occupation \_\_\_\_\_

Do you have an extended health plan?  Yes  No

Emergency Contact: \_\_\_\_\_ Telephone: \_\_\_\_\_

### Payment, Changes to appointments, and file sharing (require your initialing)

I accept full responsibility for any fees incurred during care and treatment, and am aware that I am responsible for payment at the time services are rendered. **Initials** \_\_\_\_\_

We require 24 hours notice for any changes to, or cancelation of your appointment. All appointments missed, cancelled, or rescheduled within 24 hours of the appointment will incur the full visit charge. **Initials** \_\_\_\_\_

I consent to my file being shared if I decide to see another practitioner at Avita **Initials** \_\_\_\_\_

How Did you hear about Avita Health and Massage?

Online  Clinic Website  I live nearby  Other

Word of Mouth (Give us a name-we would like to say thank you!) \_\_\_\_\_

**Office Use Only** CHARTED  SCANNED  ATTACHED

# Confidential Health Information

Main health complaint

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Other complaints

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**Have you had previous care from a...**  Chiropractor  Massage Therapist  Naturopath

If yes, name of practitioner \_\_\_\_\_ Approximate date of last visit \_\_\_\_\_

Did you have spinal x-rays?  Yes  No If yes, when? \_\_\_\_\_

Name of current General Practitioner (MD) \_\_\_\_\_

Date of last visit to GP \_\_\_\_\_

Reason for last visit \_\_\_\_\_

Are you seeing a medical specialist?  Yes  No Name of specialist \_\_\_\_\_

Reason for seeing specialist \_\_\_\_\_

**Medications** Please list any medications or supplements you are taking and state reasons for taking them.

Medications (prescription, \_\_\_\_\_  
over-the-counter) \_\_\_\_\_

Supplements (multi- \_\_\_\_\_  
vitamins, gingko, etc) \_\_\_\_\_

**Surgeries/Hospitalizations** Please list any surgeries you have had and the date.

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**Stress Level** Overall stress level:  none  low  medium  high

Main reasons for stress \_\_\_\_\_

**Exercise** How often do you exercise? \_\_\_\_\_

Type of exercise \_\_\_\_\_

**Smoking** Do you currently smoke?  Yes  No How much? \_\_\_\_\_ per day For how long? \_\_\_\_\_ years

**Goals** What would you like to gain from today's visit? \_\_\_\_\_

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**What are the two most important health goals for you?**

1. \_\_\_\_\_ 2. \_\_\_\_\_

**For women** Are you pregnant?  Yes  No  Maybe If yes, what is your due date? \_\_\_\_\_

Do you have children?  Yes  No If yes, by...  natural delivery  caesarean delivery

Menstrual cycle:  regular  irregular  cramps  painful cycle

Date of your last annual Pap/Breast exam: \_\_\_\_\_

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## Review of systems

Please check the appropriate box for any of the following symptoms and add any comments you may feel are important.

### General

- Insomnia
- Fatigue
- Weight loss
- Weight gain

### Head

- Headache
- Dizziness
- Head trauma
- Fainting
- Blacking out

### Eyes

- Itching/redness
- Change in vision
- Cataracts
- Light sensitivity
- Flashes in vision
- Spots in vision
- Glaucoma

### Ears

- Impaired hearing
- Earache
- Dizziness
- Discharge
- Ringing/tinnitus

### Mouth & Throat

- Bleeding gums
- Cold sores
- Sore throat
- Jaw/TMJ problems
- Hoarseness
- Swollen glands
- Goiter

### Nose

- Hayfever
- Loss of smell
- Nosebleeds
- Sinus problems

### Lungs

- Difficulty breathing
- Shortness of breath
- Persistent cough
- Coughing phlegm
- Coughing blood
- Asthma
- Pneumonia
- Emphysema
- Bronchitis
- Infections

### Vascular

- Angina
- Murmurs
- Heart disease

- Chest pain
- Palpitations
- Ankle swelling
- Cold feet/hands
- Leg cramps
- Calf pain
- Varicose veins
- Low blood pressure
- High blood pressure

### Gastro-Intestinal

- Bloating/gas
- Heartburn
- Ulcers
- Liver disease
- Gall bladder disease
- Vomiting/nausea
- Abdominal pain
- Diarrhea
- Constipation
- Blood in stool
- Hemorrhoids
- Hernias
- \_\_\_ number of bowel movements per day

### Gastro-Urinary

- Difficulty urinating
- Pain urinating
- Blood in urine
- Incontinence
- Bed-wetting
- Urinary urgency
- Frequent urination
- Frequent infections
- Kidney stones

### Neurological

- Seizures/epilepsy
- Strokes
- Tingling sensation
- Numbness
- Muscle weakness
- Difficulty walking
- Poor coordination
- Paralysis
- Speech problems
- Loss of memory

### Muscle & Bone

- Joint pain
- Swollen joints
- Stiffness
- Muscle ache
- Foot trouble
- Arthritis
- Bone pain
- Fractures
- Dislocations

### Skin

- Rash
- Itching/hives
- Changes in moles
- Acne
- Psoriasis
- Eczema

### Endocrine

- Diabetes
- Hypoglycemia
- Hormone therapy
- Thyroid problems
- Heat/cold intolerance
- Excessive thirst
- Excessive hunger
- Excessive sweating
- Night sweats

### Emotional

- Depression
- Mood swings
- Anxiety/nervousness
- Tension
- Phobias
- Alcohol/drug abuse

### Conditions

- AIDS/HIV
- Alcoholism
- Anemia
- Cancer/tumor
- Chronic fatigue
- Eating disorder
- Fibromyalgia
- Gout
- Headache unlike any ever experienced
- Heart condition
- Hepatitis
- High cholesterol
- Migraines
- Multiple sclerosis
- Osteoarthritis
- Osteoporosis
- Parkinson's
- Polio
- Rheumatic arthritis
- Rheumatic fever
- TIAs (Transient Ischemic Attacks)

Using the following symbols, please indicate directly on the body diagrams below the area of your complaint and the type of pain experienced.

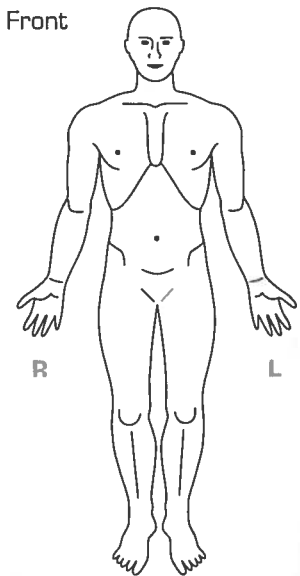
X Burning

O Dull/achy

△ Sharp

□ Numbness/tingling

Front



Back

