Avita

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

Other complaints

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.

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?

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:

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.

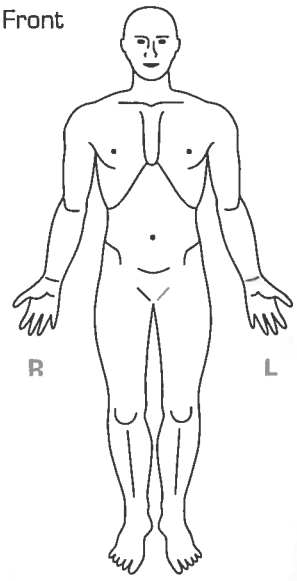
X Burning

O Dull/achy

△ Sharp

☐ Numbness/tingling

Front



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