

**Dr. Paul Chauhan**  
**PATIENT INFORMATION**

Name (as on Care Card) \_\_\_\_\_ Care Card # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Birthdate \_\_\_\_\_  
(mmm/dd/yr)

Emergency contact name & number \_\_\_\_\_ Number of children \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Email: \_\_\_\_\_ Permission to email you newsletters Y\_\_N\_\_

**Appt Reminders: Email**  **Text**  \_\_\_\_\_ **Phone**  **Receipts: Print**  **Email**  **None**

(Cell Provider)

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\_\_ Claim # \_\_\_\_\_ WCB Claim Y\_\_N\_\_ Claim # \_\_\_\_\_

Purpose of this visit \_\_\_\_\_

**IF YOU HAVE EXTENDED HEALTH BENEFITS PLEASE LET FRONT DESK KNOW BEFORE APPT**

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**(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 \_\_\_\_\_

**MEDICAL BACKGROUND:**

What surgeries have you had \_\_\_\_\_ When \_\_\_\_\_

Have you broken any bones? Y\_\_N\_\_ Where \_\_\_\_\_

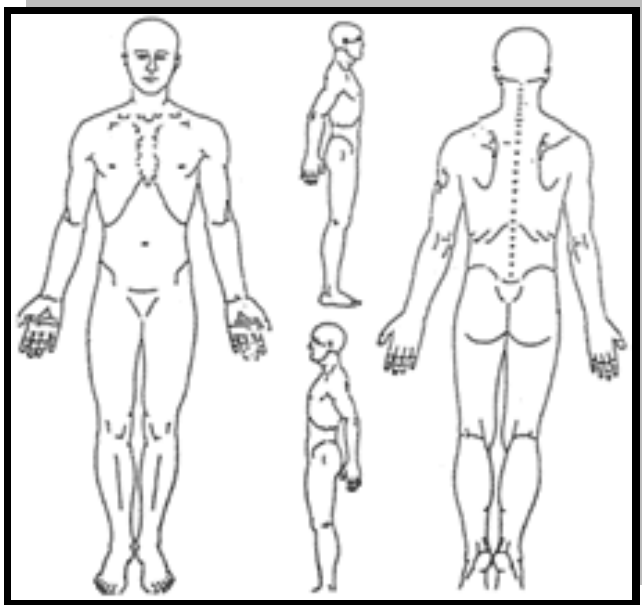
Have you been in any vehicle accidents? Y\_\_N\_\_ When \_\_\_\_\_

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 my nervous system healthy
- Have a healthier spine
- Live a healthier lifestyle