OKANAGAN HEALTH & PERFORMANCE

Family & Sports Chiropractic, Massage Therapy, Kinesiology & Naturopathic Medicine

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Dear Patient, welcome to **Okanagan Health & Performance**. Thank you for entrusting us with your health.

PERSONAL INFORMATION

First Name ______________________ Initial _____ Last Name ___________________ Care Card # _________________________

Birthdate: MM ______ DD ______ YY _________ Age ___________ Gender: M _____ F _____

Address ______________________________City _______________________ Prov __________ Postal Code __________________

Phone: Home __________________________ Work ________________________________ Cell ____________________________

Email ____(for appt reminders and our newsletter)

Type of Work ____ Employer ____

Marital Status: S___ M ___ D___ Sep ___ W ___ Number of children _______

Emergency Contact ____ Phone Number ______________________________

How did you hear about us? Referred by: ____________________________ Phone book ___ Sign ___ Other __________________

What are the most important health concerns that you are seeking treatment for/or are currently being treated for? List in order of importance.

1- ____

2- ____

3- ____

4- ____

MEDICAL HISTORY AND INFORMATION

Your Medical Practitioner's Name: ____ Phone: ______________________

Date last seen _____________ Reason for visit ___________________ Recent medical testing: Xrays___ Blood test ____ Other____

How is your health in general? ___Excellent ___Good ___Fair ___Poor

Please indicate any serious conditions, illnesses, injuries, and hospitalizations, along with dates:

1- ____

2- ____

3- ____

4- ____

Please list any prescription medications, over-the-counter medications, vitamins or other supplements you are taking, the dosage, and the reasons for taking them:

1- ____

2- ____

3- ____

4- ____

Are you hypersensitive or allergic to any of the following (please list)

Drugs? ____

Foods? ____

Environmental? (e.g. pollen, dust, perfume) ____

____

Do you frequently use any of the following? (Circle)

Aspirin / Laxatives / Antacids / Diet pills / Birth control: pills / implants / injections

Alcohol: amount per day or week ____________________

Tobacco: amount per day ____________________

Caffeine: form and amount per day ____________________

Recreational drugs: what and how often ____________________

How many times have you been treated with antibiotics? ____________________

Please indicate what immunizations you have had:

___DPT (diphtheria, pertussis, tetanus) ___Hemophilus influenza B ___Hepatitis A

___MMR (measles, mumps, rubella) ___"Flu" ___Hepatitis B

___Smallpox ___Polio

___Other: ____________________

Please describe any adverse reaction: ____________________

FAMILY HISTORY

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		Who?
Allergies		High blood pressure	
Alcoholism		Kidney disease	
Asthma		Mental illness	
Arthritis		Mononucleosis	
Cancer (type)		Multiple Sclerosis	
Chronic Bronchitis		Osteoporosis	
Diabetes		Rheumatic Fever	
Depression		Skin diseases	
Drug abuse		Strep throat	
Emphysema		Stroke	
Hepatitis		Tuberculosis	
Heart disease		Other	

TYPICAL FOOD INTAKE

Breakfast: ____________________
Lunch: ____________________
Dinner: ____________________
Snacks: ____________________
Beverage: ____________________
Cravings: ____________________
Aversions: ____________________
Do you have any dietary restrictions? ____________________

GENERAL INFORMATION

How many hours do you sleep per night? __________ Do you sleep well? Y / N
Do you exercise regularly? Y / N What do you do for exercise, how much, how often?
____
How often do you (in a day): have a bowel movement? __________ Urinate? __________
What are your interests and hobbies? ____________________
Describe the emotional climate at home and at work
____
What do you do to relax and cope with stress? ____________________
Is there anything that you feel is important that has not been covered? ____________________
____