arise
CHIROPRACTIC
MASSAGE • YOGA
WELLNESS CORPORATION

Personal Information

Your name: _____
First Last

Birth date: _____ Age: _____

Marital status: _____

Occupation: _____

B.C. Personal Health Number: _____

Is your visit today WCB or ICBC related? _____

Address: _____

Postal code: _____

Telephone: Home:_____ Cell: _____

Email address: _____

Referred to our clinic by: _____

Note: Your email will be used as a secondary contact and occasionally clinic info (i.e specials and event info) might be sent to you. You can unsubscribe at any time if you choose.

Previous chiropractor: _____ City: _____

Last visit & reason for leaving: _____

Current Medical Clinic: _____ City: _____

Your main complaint(s):Primary: _____

Secondary:_____

How long have you suffered with this? Primary: _____

Secondary: _____

What steps have you taken that **DID NOT** work? _____

Have you become discouraged about handling this problem? _____

When your problem is at its worst, how does it make you feel? _____
How does this problem interfere with the following areas of your life?

WORK: _____

FAMILY: _____

HOBBIES: _____

What do you do that makes this problem worse? _____

On a scale of 1 to 10, rate your commitment in helping us solve this problem: _____

What gives you some temporary relief? _____

What is the pattern of this problem? Constant ___ Intermittent ___ Occasional ___ Cyclic ___

What is the effect it has on your body's functions? _____

How did it start? _____

List any medications you take:_____

Could your problem have been caused by an injury at work?_____

If yes, please give us the details: _____

Have you been involved in an auto accident? _____

Date of accident: _____

Any difficulties from this?_____

Do you have any children? _____

Do they have any health problems you are aware of? _____

SIGNATURE: _____ **DATE**: _____