NUCCA Kelowna

Suite #209 1890 Cooper Road, Kelowna, BC V1Y 8B7

Phone: (778)484-7111 Fax:

(778)484-7112

www.nuccakelowna.com

File #

The Doctors. Therapists and Staff wish to welcome you and want to provide you with the best possible care!

	P	atier	nt In	form	atior	<u>1</u>					
Name:							Date	e:			
Address:			0.00				PDOWNOF			POSTAL	0005
Phone Numbers: ()											CODE
Email Address:											k 🗆 email
Occupation:				Emple	oyer: _						
				Sex:	□м	□F.	Age:	Bi	irthdate	e	7 D / Y
In case of emergency, who should we conta	ct? N	ame:								М	7 6 7 7
Relationship				Phone	e: <u>(</u>)			()	
Who can we thank for referring you?				Text	83	14 N	HOME	_		WOF	RK
Have you seen a chiropractor before?		Yes	□No	Who:							
Have you seen a massage therapist before											
Family Information						176	90 DD 5	- 19424 90		ANT	
				Accident Information Is this condition due to an accident? □ Yes □ No							
Spouse/Partner name:				☐ Automobile? ☐ Slip or fall? ☐ Work?							
Children: How many? Ages:				Do you have an active insurance case? ☐ Yes ☐ No							
Ages				Are you starting an insurance case? ☐ Yes ☐ No							
What brings you in today (pain/problem o	r cond					<u>aire</u>					
Severity of pain (circle one):		2	3	4	M / Y	6	7	8	9	10	Н
What do you think caused this complaint?			1505	694	5			8	9	10	
2)		Onse	et?		M / Y						
Severity of pain (circle one):	1	2	3		5	6	7	8	9	10	Н
What do you think caused this complaint?_											
What makes it better?											
What makes it worse?											
3)											
fi .	1		3		м / Y 5	6	7	8	9	10	Н
What do you think caused this complaint?_				100							
What makes it better?											
What makes it worse?											

NUCCA Kelowna

Difficulty Urinating

Digestive Problems

Insomnia

Irritability

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Date of last Period (if applicable)

File # __

	Please circle numbers be	elow corresponding to symptom from pre	vious section.								
What time of day is the pain the worst? Morning: 1 2 3 Aflemoon: 1 2 3 Evening: 1 2 3 Night: 1 2 3 All the time: 1 2 3 The pain is: Occasional: 1 2 3 Frequent: 1 2 3 Constant Is the pain local: Yes: 1 2 3 No: 1 2 3 Does the pain travel or radiate down the arm or leg: Yes: 1 2 3 No: 1 2 3 Please mark where you have pain. **Now far?** Do you have any pain: 1 2 3 numbness: 1 2 3 tingling: 1 2 3 pins and needles, in the hands or: 1 2 3 feet: 1 2 3 Yes: 1 2 3 No: 1 2 3 **Does the pain affect your sleep Yes: 1 2 3 No: 1 2 3 **Does the pain affect your sleep Yes: 1 2 3 No: 1 2 3 **Does the pain affect your sleep Yes: 1 2 3 No: 1 2 3 **Please mark where you have pain. **X = sharp N = burning = dull **Please mark where you have pain. **X = sharp N = burning = dull **Physical History** Please describe and date: **Any Falls:** **Please mark where you have pain. **X = sharp N = burning = dull **Physical History** Please describe and date: **Any Accidents:** **Any Accidents:** **Any Accidents:** **Any Broken Bones:** **Any Broken Bon	Describe the pain: Sharp	(knife like): 1 2 3 Dull (like a tooth-ache): 1 2 3	{ }	{	()					
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Polio

Prostrate Problems