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!

Patient Information

Name: _____ (FIRST / LAST) Date: _____

Address: _____ (STREET / CITY / PROVINCE / POSTAL CODE)

Phone Numbers: (___) _____ HOME (___) _____ CELL (___) _____ WORK

Email Address: _____ Preferred contact: ☐ Cell ☐ Home ☐ Work ☐ email

Occupation: _____ Employer: _____

Sex: ☐ M ☐ F Age: _____ Birthdate _____ (M / D / Y)

In case of emergency, who should we contact? Name: _____

Relationship _____ Phone: (___) _____ HOME (___) _____ WORK
Text

Who can we thank for referring you? _____

Have you seen a chiropractor before? ☐ Yes ☐ No Who: _____

Have you seen a massage therapist before? ☐ Yes ☐ No Who: _____

Family Information

☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse/Partner name: _____

Children: How many? _____ Ages: _____

Accident Information

Is this condition due to an accident? ☐ Yes ☐ No

☐ Automobile? ☐ Slip or fall? ☐ Work?

Do you have an active insurance case? ☐ Yes ☐ No

Are you starting an insurance case? ☐ Yes ☐ No

Symptom Questionnaire

What brings you in today (pain/problem or concern)?

1) _____ Onset? (M / Y)

Severity of pain (circle one): L 1 2 3 4 5 6 7 8 9 10 H

What do you think caused this complaint? _____

What makes it better? _____

What makes it worse? _____

2) _____ Onset? (M / Y)

Severity of pain (circle one): L 1 2 3 4 5 6 7 8 9 10 H

What do you think caused this complaint? _____

What makes it better? _____

What makes it worse? _____

3) _____ Onset? (M / Y)

Severity of pain (circle one): L 1 2 3 4 5 6 7 8 9 10 H

What do you think caused this complaint? _____

What makes it better? _____

What makes it worse? _____

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Please circle numbers below corresponding to symptom from previous section.

Describe the pain: Sharp (knife like): 1 2 3 Dull (like a tooth-ache): 1 2 3

Burning (hot): 1 2 3 Other: _____

What time of day is the pain the worst? Morning: 1 2 3 Afternoon: 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

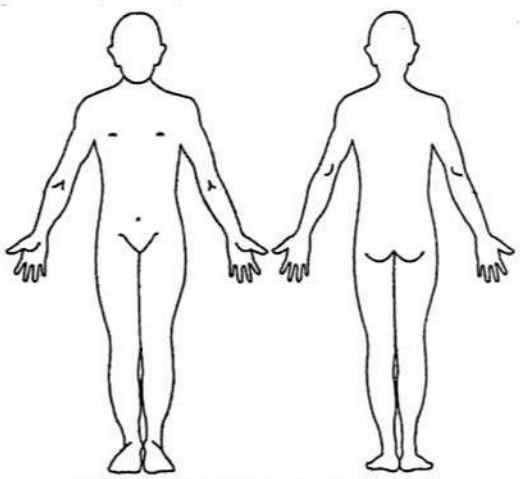
Does the pain travel or radiate down the arm or leg: Yes: 1 2 3 No: 1 2 3

How 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



Please mark where you have pain.
X = sharp \\ = burning • = dull

Social History

Height: ____ft ____in Weight: ____lbs

How much alcohol do you drink per week? _____

How much coffee do you drink per day? _____

How much water do you drink per day? _____

Do you love sweets? ☐ Y ☐ N Do you crave salt? ☐ Y ☐ N

Do you smoke? ☐ Y ☐ N Do you stretch daily? ☐ Y ☐ N

How many times a week do you exercise? _____

What type of execise do you do? _____

How would you rate your daily stress level? L 1 2 3 4 5 H

Physical History

Please describe and date:

Any Falls: _____

Any Accidents: _____

Any Broken Bones: _____

Any Surgeries: _____

Any Hospitalizations: _____

Health History

	Present	Past	No
Anxiety	___	___	___
AIDS/HIV	___	___	___
Alcoholism	___	___	___
Allergies	___	___	___
Anemia	___	___	___
Appendicitis	___	___	___
Arthritis	___	___	___
Asthma	___	___	___
Bleeding Disorders	___	___	___
Breast Lumps	___	___	___
Bronchitis	___	___	___
Bursitis	___	___	___
Cancer	___	___	___
Cataracts	___	___	___
Chemical Dependency	___	___	___
Chicken Pox	___	___	___
Diabetes	___	___	___
Difficulty Urinating	___	___	___
Digestive Problems	___	___	___

	Present	Past	No
Dizziness	___	___	___
Eating Disorders	___	___	___
Edema	___	___	___
Emphysema	___	___	___
Epilepsy	___	___	___
Fainting	___	___	___
Glaucoma	___	___	___
Goiter	___	___	___
Gonorrhoea	___	___	___
Gout	___	___	___
Heart Disease	___	___	___
Hepatitis	___	___	___
Hernia	___	___	___
Herniated Disc	___	___	___
High Blood Pressure	___	___	___
High Cholesterol	___	___	___
Immunizations	___	___	___
Insomnia	___	___	___
Irritability	___	___	___

	Present	Past	No
Kidney Disease	___	___	___
Liver Disease	___	___	___
Loss of Balance	___	___	___
Measles	___	___	___
Menstrual Difficulties	___	___	___
Migraine Headaches	___	___	___
Miscarriage	___	___	___
Mononucleosis	___	___	___
Multiple Sclerosis	___	___	___
Mumps	___	___	___
Nausea	___	___	___
Nervousness	___	___	___
Osteoporosis	___	___	___
Pacemaker	___	___	___
Parkinson's Disease	___	___	___
Pinched Nerve	___	___	___
Pneumonia	___	___	___
Polio	___	___	___
Prostrate Problems	___	___	___

	Present	Past	No
Psychiatric Care	___	___	___
Rheumatoid Arthritis	___	___	___
Rheumatic Fever	___	___	___
Scarlet Fever	___	___	___
Sciatica	___	___	___
Sprains/Strains	___	___	___
Stroke	___	___	___
Thyroid Problem	___	___	___
Tonsilitis	___	___	___
Tuberculosis	___	___	___
Tumours/Growths	___	___	___
Typhoid Fever	___	___	___
Ulcers	___	___	___
Vaginal Infections	___	___	___
Varicoseveins	___	___	___
Whooping Cough	___	___	___
Hysterectomy	☐ Yes	☐ No	
Are you Pregnant?	☐ Yes	☐ No	
Date of last Period (if applicable)	_____		