NUCCA Kelowna

649 Cadder Avenue
Kelowna, BC V1Y 5N5
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: _____

B.C Care #: _____ 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

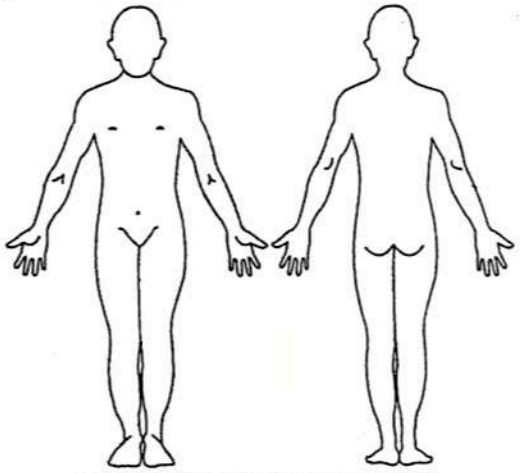
Does the pain travel or radiate down the arm or leg: Yes: 1 2 3 No: 1 2 3

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)	_____		