# WELCOME TO SHIKAZE CHIROPRACTIC

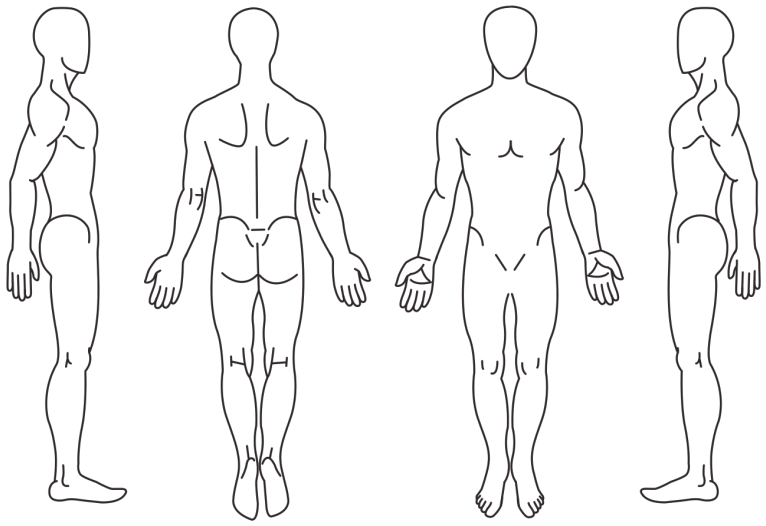
## PERSONAL INFORMATION

| | | | | |
|---|---|---|---|---|
| Name: | | | Address: | |
| City: | Province: | Postal Code: | | Phone: |
| Birth Date: | Age: | Height: | Weight: | Marital Status: |
| Name of Spouse: | | | Employer: | |
| Occupation: | | Medical Doctor: | | Last Consulted: |
| Email: | | | Personal Health #: | |
| How did you hear about us? (Check): | | ☐ Google | ☐ Facebook | ☐ Yellow Pages: |
| | | ☐ Referral (specify): | | ☐ Other (specify): |
| Extended Health Care/Insurance Provider: | | | | |
| Is this a WSBC or ICBC claim? | ☐ No | ☐ Yes (Claim Number): | | |

## CURRENT HEALTH COMPLAINT

| | |
|---|---|
| Where is the location of your complaint? | |
| How did this happen? | |
| When did this happen? | Is this getting better, worse or the same? |
| What are your limitations due to this? | |
| What aggravates your complaint? | |
| What gives you relief? | |
| Is this affecting your sleep? | |
| Has this occurred before? | Is this an acute or chronic injury? |
| Have you experienced any unexplained weight loss? | |
| Have you experienced any dizziness? | |
| Is this your first time consulting a chiropractor? | Are you uneasy about seeing a chiropractor? |
| Do you wear any orthotics or shoe supports? | |

**Body Diagram:**



Please **mark** on the **diagram** the **area** of **your complaint** with the following **symbols** or **write** your **description** of **discomfort** over the **diagram**.

Dull Ache: **OOO**

Stiff/Tight: ///

Sharp/Stabbing: **✖✖✖**

Numbness: ???

Tingling/Pins & Needles: ≈ ≈ ≈

Cold: vvv

Burning: ΛΛΛ

Weakness: – – –

******PLEASE CONTINUE ONTO THE OTHER SIDE******

SHIKAZE CHIROPRACTIC

## PAST MEDICAL HISTORY

Please check if you have had any of the following health conditions:

| | | | |
|---|---|---|---|
| ☐ Asthma | ☐ Heart Disease | ☐ Shingles | ☐ Osteoarthritis |
| ☐ COPD/Emphysema | ☐ High Blood Pressure | ☐ Cirrhosis | ☐ Rheumatoid Arthritis |
| ☐ Diabetes (Type I or II) | ☐ Low Blood Pressure | ☐ Hepatitis: A, B, C? | ☐ Ankylosing Spondylitis |
| ☐ Hyper/Hypo Thyroid | ☐ High Cholesterol | ☐ HIV/AIDS | ☐ Inguinal Hernia |
| ☐ Crohn's | ☐ Heart Attack | ☐ Epilepsy | ☐ Abdominal Hernia |
| ☐ Ulcerative Colitis | ☐ Stroke / TIA | ☐ Anxiety / Depression | ☐ Prostate Enlargement |
| ☐ Psoriasis | ☐ Deep Vein Thrombosis | ☐ Kidney Stones | ☐ Endometriosis |

Other health conditions:

History of cancer? Please specify:

Current medications:

Previous surgeries:

Previous fractures / Dislocations:

Past major accidents or falls?

Past motor vehicle accidents?

Ever suffered from a concussion or knocked unconscious?

## ASSIGNMENT

(Applies only to those patients who are receiving subsidy from The BC Medical Services Plan or those receiving health care benefits from an ongoing claim with ICBC or Work Safe BC)

I request that benefits payable to me under the medical and health care services act for chiropractic care rendered by the chiropractor listed below be made payable in my name and mailed to his/her address. Further, I irrevocably assign these amounts to the chiropractor listed below and direct that they be applied, as received against the outstanding balance of monies owing by me to the chiropractor listed below on the account of chiropractic care provided.

Name: Signature:

Witness: Date:

## CANCELLATION / MISSED APPOINTMENT POLICY

Shikaze Chiropractic requires a minimum of 6 hours of notice for any cancellation or rescheduling. Any short notice cancellations or missed appointments will be subject to a fee up to 50% of the original cost of the appointment. We understand that there are certain situations that may arise where you may not be able to cancel or need to make a last-minute change to your appointment. Please contact the office immediately regarding your situation. If you have any questions regarding our office policies, please do not hesitate to contact our office. We wish to provide you with the best possible care.

## LATE ARRIVALS

In the event of a late arrival, we will do our best to move your appointment into the next available opening; however, if there is no alternative opening, we will reschedule your visit.

I agree to the above terms regarding the cancellation, missed appointment, and late arrival policy:

Name: Signature:

Witness: Date: