Kilian Chiropractic
27240 30th Avenue
Aldergrove, BC V4W 3J6
604-856-7781
info@kilianuppercervical.com

Claiming through ICBC? YES or NO

My Appointment:_____

Patient History

Name:_____ Date:_____
Address:_____ City:_____
Prov.:_____Postal Code:_____ Home Phone:_____
Cell Phone:_____ Work Phone:_____
Email:_____
Birth Date: (M/D/Y)_____ / _____ / _____ Gender: Male or Female
Occupation:_____ Spouse: _____

How did you hear about our office?_____

Do you have extended health care benefits? Yes No ***If yes, please find out the details before your next visit***

What is your chief complaint - the reason you came to Kilian Chiropractic?

_____

Do you experience Neck Pain?____ Mid Back Pain?____ Low Back Pain?____ Headaches?____

How long have you been tolerating your main complaint?_____

Have you had this problem in the past? Yes No If yes, when?_____

Have you seen other practitioners for this problem? Yes No
If yes, whom? (circle all that apply)

Chiropractor Massage Naturopath Acupuncture TCM Medical Doctor

Neurologist Orthopedist Personal Trainer Physiotherapist

What makes the problem worse?_____

Do you experience tingling, numbness or pain travelling down your:

Arms? Yes No Legs? Yes No

What is the severity of pain on a scale of 1/10 today? _____ /10 At its worst? _____ /10
How long ago was it at its worst?_____

When does pain occur? AM PM Varies All Day

What specific activities does it interfere with? (work, sleep, leisure, sleeping, driving, etc.)

_____

Have you lost time from work because of it? Yes No If yes, when?_____

Do you "crack" your own (circle which apply): Neck ◯ Mid Back ◯ Low Back ◯

Rate your level of commitment to resolving this/these problems. (10 being the highest)

1 2 3 4 5 6 7 8 9 10

On the diagram below, show where you are experiencing all of your present complaints using the following letters:

A: Aching

B: Burning

C: Cramping

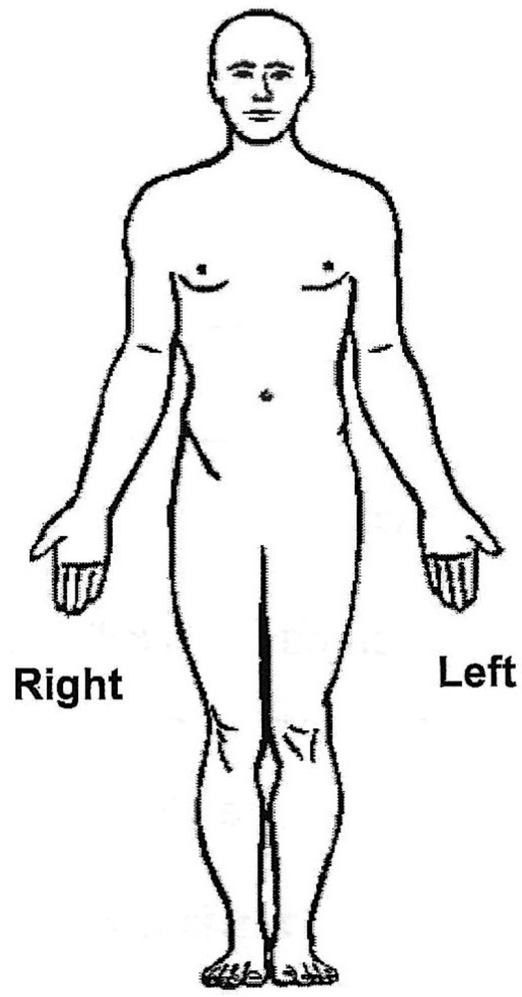
D: Dull

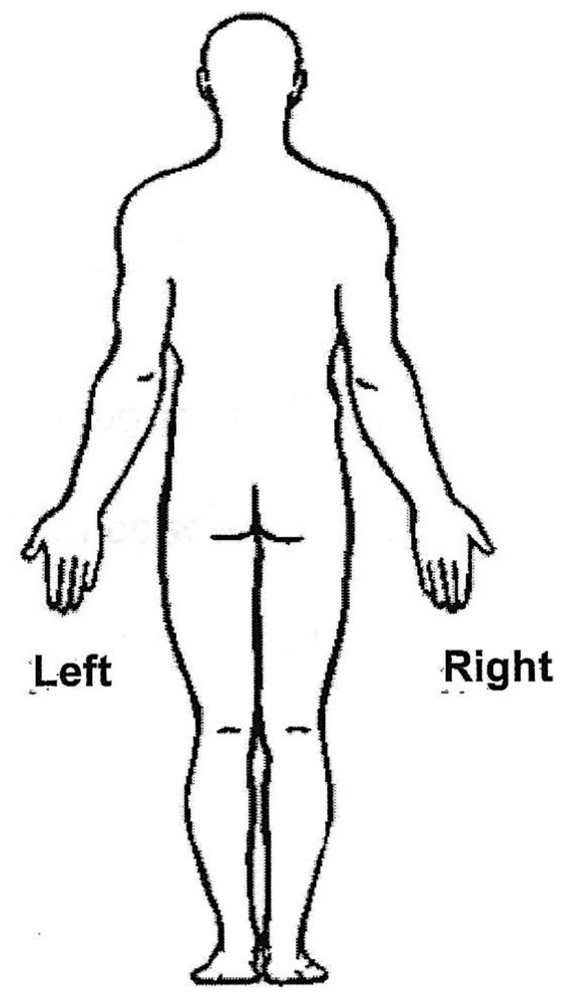
TI: Tight

N: Numbness or Tingling

TH: Throbbing

S: Stiff





List all Motor Vehicle Accidents you have had (approximate dates and severity):

_____

_____

List all past impacts, hard falls, sports injuries, concussions, broken bones, etc. (approximate dates and severity): _____

_____

How many hours a day do you spend sitting? (work, travel, and home total) _____

List any type of exercise you do and frequency per week: _____

_____

List all medication you are currently taking:_____

_____

List all major surgeries you have had (approximate dates): _____

_____

Do you have a family history of: Arthritis ◯ Cancer ◯ Heart Disease ◯ Diabetes ◯

Are you pregnant? Yes No If yes, when is your due date?_____