

# Kilian Chiropractic

Unit 205 (mall level)  
555 Burrard Street, Box 221  
Vancouver BC V7X 1M7

## Easiest way to find our office:

Enter the Bentall Centre at the corner of West  
Pender and Burrard Street. Go down the escalator.  
Kilian Chiropractic is straight ahead (20 meters)

**My Appointment:** \_\_\_\_\_

## Patient History

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
Prov.: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Email: \_\_\_\_\_  
Birth Date: (D/M/Y) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Gender: Male or Female  
Occupation: \_\_\_\_\_ Spouse: \_\_\_\_\_  
Strong side: Right or Left Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
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

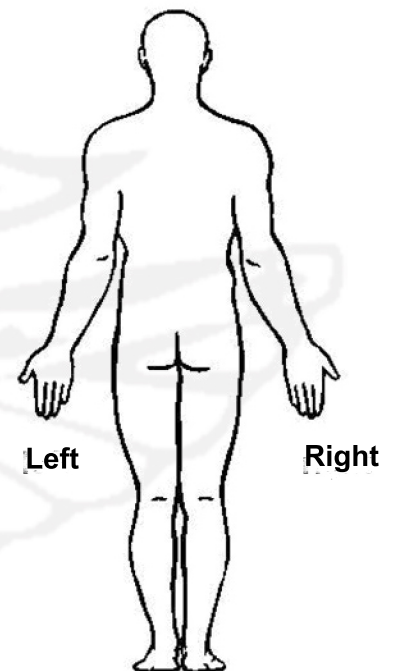
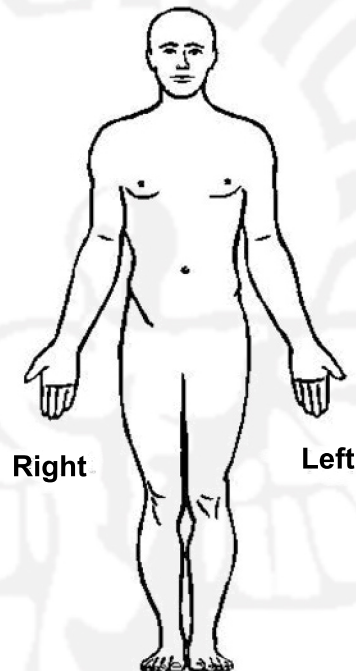
● D: Dull

● Tl: Tight

● N: Numbness or Tingling

● TH: Throbbing

● S: Stiff



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

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

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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: \_\_\_\_\_

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List all medication you are currently taking: \_\_\_\_\_

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

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

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