Dr's Shaun & Lana Patterson
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New Patient Health Profile (Adult 13+)

Date (MM/DD/YY): _____

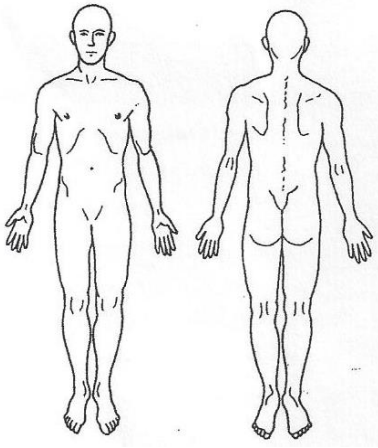
Last Name: _____ First Name: _____
Date of Birth (MM/DD/YY): _____ Age: _____ Gender: O M O F O Other
Home #: _____ Cell #: _____
Address: _____ City & Postal Code: _____
Email Address: _____ Occupation: _____
Name of Spouse: _____ Name(s) of Children: _____
Emergency Contact: _____ Emergency Contact Ph#: _____

Who can we thank for sending you to our office? _____

Please notify Reception if you have an <u>active</u> ICBC or WorkSafeBC claim.

<u>Are you pregnant?</u> **O Yes*** (Due Date: _____) **O No** ***If yes, please notify the doctor***

CIRCLE AREAS OF CONCERN



Describe your areas of concern: _____

_____

When did it start? _____

What do you think caused this? _____

Type of pain:	O Sharp	O Ache	O Stiff	O Numb
How intense is your pain?	O No Pain	O Mild	O Moderate	O Severe
How frequent is your pain?	O Occasional	O Constant		
Does it travel?	O Yes	O No		

What makes it better? _____

What makes it worse? _____

Any past treatments for this complaint? O None O Acupuncture O Physio O Massage O Other

PAST HISTORY

Have you ever had chiropractic care before? O Yes O No

List of past issues/concerns (heart attack, cancer, digestive problems, depression, etc.) _____

List any hospitalizations and/or surgeries: _____

List any Motor Vehicle Accidents (including dates and injuries): _____

List any major accidents/ falls/ concussions: _____

Current medications and/or supplements: _____

List any family health conditions (i.e. Arthritis, Diabetes, Cancer, Heart Disease): _____

Rate your quality of sleep:	O Excellent	O Good	O Ok	O Poor	O Terrible
Rate the level of your stress:	O Excellent	O Good	O Ok	O Poor	O Terrible

List any sports, exercises, and common activities: _____