EQUINOX HEALTH CLINIC
PREVENT. PERFORM. RECOVER.

Confidential Patient History Form

Name:

Date of Birth(yyyy/mm/dd):

Address:

Familly Doctor:
Phone:

Phone:

Email:

Referring Professional:
Phone:

Occupation:

How did you hear about the Clinic?

Care Card #

ICBC or WCB open Claim Y | N

Equinox Health Clinic has a 24 hrs cancelation policy, if you do not show up for your appointment you will be asked to pay $25 for the missed visit. If you are late for your visit you will still be charged the original time. *Please initial that you understand these conditions* :

Please indicate if you believe any of the following apply to you? (P=past C=current)

_ Heart Attack
_ High / Low Blood Pressure
_ Stroke or Aneurysm
_ Pace Maker
_ other Heart condition
_ Varicose Veins
_ Bruise easily
_ other Circulatory condition
_ Diabetes
_ Kidney Disease
_ other Urinary condition
_ Headaches / Migraines
_ Dizziness / Fainting
_ Nausea
_ Spinal Injury
_ Head Injury
_ Epilepsy / other seizures
_ other Neurological condition
_ Asthma
_ Chronic Sinusitis
_ other Respiratory condition
_ Irritable Bowel / Colitis
_ Digestive condition
_ Skin condition
_ Joint Dislocation
_ Bone Fracture
_ Arthritis
_ Osteoporosis
_ Rods / Pins / Plates / Shunts
_ Implants
_ Transplant
_ Corrective Lenses/Contacts
_ Cancer
_ Hepatitis
_ HIV
_ other Contagious condition

Please list any medication you are presently taking:

Please list every known allergy (including medications, foods, seasonal, oils and lotions, etc.)

Have you ever been hospitalized; had any major accidents, illnesses or surgeries? Y | N
Please comment:

Current Condition:

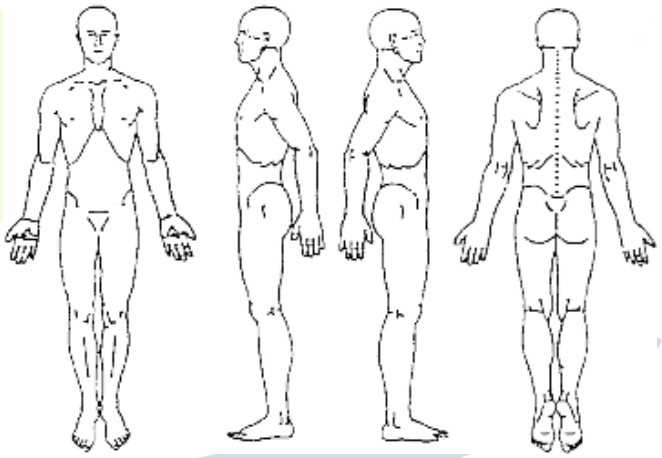
Please describe your current problem and symptoms:

Have you had any diagnostic tests such as an X-Ray, MRI, CT Scan or other for this problem? If so please indicate.

How long have you had this condition:

What aggravates it?
What relives it?

Please Indicate on the diagram the location of your symptoms :



Rate your pain:

0-1-2-3-4-5-6-7-8-9-10

Present Quality of sleep: 0=poor 5=excellent

0-1-2-3-4-5 hrs/night?

Present Stress levels: 0=poor 5=excellent

0-1-2-3-4-5

Present Exercise habits: (times per week)

0-1-2-3-4-5...

Previous injuries (Please List):

Smoker : Y|N

Other useful information that should be disclosed?

Please Note: Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and its associated RMTs to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated practitionners to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature:

Date: