Lifeforce Proactive
HEALTH CENTRE

Please Circle or Describe Date: ______________ Case #: ______________

Salutation: Mr. Mrs. Miss Ms. _____ First Name: ______________ Last Name: ______________

Birth Date: M ____ D ____Y ____ Age _____ M.S.P. #______________

Address: ______________ City: ______________

Province: __________ Postal Code: ____________ **E-Mail Address:** ______________

Home Phone: ______________ Work Phone: ______________

Employer: ______________ Type of Work: ______________

Extended Insurance? ■Yes ■ No Name of Extended Insurance Carrier:______________

Is this visit a result of a Motor Vehicle Accident or Work Safe BC Injury? ■ Yes ■ No

If yes, please advise the receptionist.

HEALTH HISTORY

REFERRAL SOURCE

- ❑ Friend or Family ____________
- ❑ Practitioner ____________
- ❑ Yellow Pages ❑ Internet
- ❑ Signage ❑ Live in area
- ❑ Other ____________

- Family Dr.: ______________
- Purpose of this Appointment? ______________
- What is your primary complaint? ______________
- When did this condition begin? ______________
- Is your condition getting better, worse or staying the same? __________
- What aggravates your condition? ______________
- What relieves your condition? ______________
- Are there others in your family with this same condition? ■ Yes ■ No
- Have you seen any other health practitioner's for this condition? ■ Yes ■ No

  If yes, Who?______________
- Medication you are taking now ■ Nerve pills ■ Pain Killers/Muscle Relaxers ■ Blood Pressure ■ Insulin ■ Aspirin/Similar ■ Other ______________

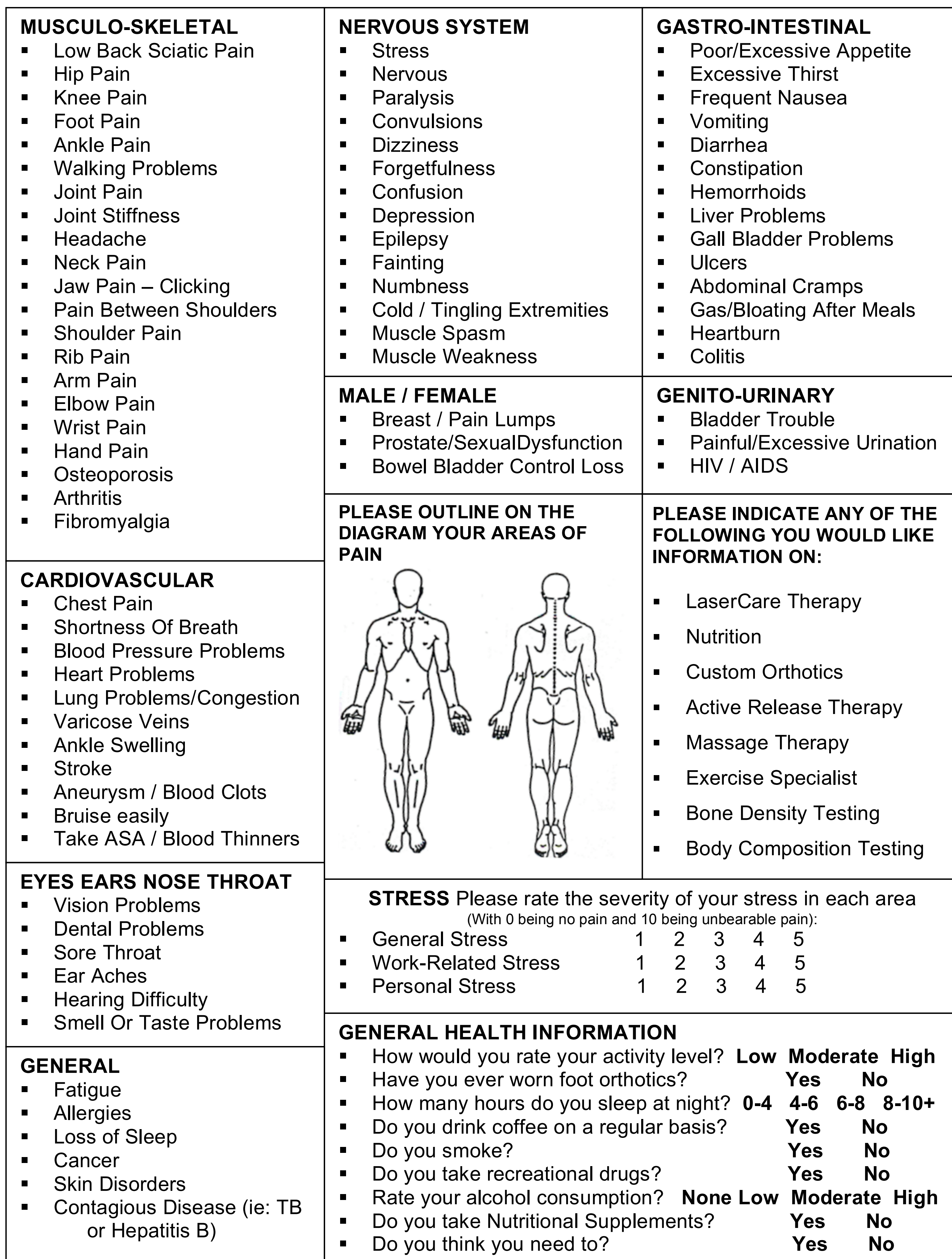
  If yes, for what condition? ______________
- Major Illnesses / Surgery / Operations? ______________
- Major accidents or Falls ______________
- Hospitalization (other than above) ______________
- Family history of illness or Disease ______________

  ____
- Have you ever had X-rays before? ■ Yes ■ No

  If yes, when and why ______________

Females only

- When was your last period ___________ Are you pregnant? ■ Yes ■ No If Yes, Due date ____________
- Did you have severe back pain during or after your pregnancy? ■ Yes ■ No # of Children ____________
- Do you experience menstrual irregularity or cramping? ■ Yes ■ No
- Are you Menopausal ■ Yes ■ No Date of Last Bone Density Assessment______________



Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these symptoms can affect your overall course of care.

CIRCLE ANY OF THE FOLLOWING SYMPTOMS YOU HAVE HAD IN THE PAST 6 MONTHS

MUSCULO-SKELETAL
- Low Back Sciatic Pain
- Hip Pain
- Knee Pain
- Foot Pain
- Ankle Pain
- Walking Problems
- Joint Pain
- Joint Stiffness
- Headache
- Neck Pain
- Jaw Pain – Clicking
- Pain Between Shoulders
- Shoulder Pain
- Rib Pain
- Arm Pain
- Elbow Pain
- Wrist Pain
- Hand Pain
- Osteoporosis
- Arthritis
- Fibromyalgia

CARDIOVASCULAR
- Chest Pain
- Shortness Of Breath
- Blood Pressure Problems
- Heart Problems
- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke
- Aneurysm / Blood Clots
- Bruise easily
- Take ASA / Blood Thinners

EYES EARS NOSE THROAT
- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Smell Or Taste Problems

GENERAL
- Fatigue
- Allergies
- Loss of Sleep
- Cancer
- Skin Disorders
- Contagious Disease (ie: TB or Hepatitis B)

NERVOUS SYSTEM
- Stress
- Nervous
- Paralysis
- Convulsions
- Dizziness
- Forgetfulness
- Confusion
- Depression
- Epilepsy
- Fainting
- Numbness
- Cold / Tingling Extremities
- Muscle Spasm
- Muscle Weakness

GASTRO-INTESTINAL
- Poor/Excessive Appetite
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Ulcers
- Abdominal Cramps
- Gas/Bloating After Meals
- Heartburn
- Colitis

MALE / FEMALE
- Breast / Pain Lumps
- Prostate/SexualDysfunction
- Bowel Bladder Control Loss

GENITO-URINARY
- Bladder Trouble
- Painful/Excessive Urination
- HIV / AIDS

PLEASE OUTLINE ON THE DIAGRAM YOUR AREAS OF PAIN

PLEASE INDICATE ANY OF THE FOLLOWING YOU WOULD LIKE INFORMATION ON:
- LaserCare Therapy
- Nutrition
- Custom Orthotics
- Active Release Therapy
- Massage Therapy
- Exercise Specialist
- Bone Density Testing
- Body Composition Testing

STRESS Please rate the severity of your stress in each area
(With 0 being no pain and 10 being unbearable pain):
- General Stress 1 2 3 4 5
- Work-Related Stress 1 2 3 4 5
- Personal Stress 1 2 3 4 5

GENERAL HEALTH INFORMATION
- How would you rate your activity level? **Low Moderate High**
- Have you ever worn foot orthotics? **Yes No**
- How many hours do you sleep at night? **0-4 4-6 6-8 8-10+**
- Do you drink coffee on a regular basis? **Yes No**
- Do you smoke? **Yes No**
- Do you take recreational drugs? **Yes No**
- Rate your alcohol consumption? **None Low Moderate High**
- Do you take Nutritional Supplements? **Yes No**
- Do you think you need to? **Yes No**