New Patient Information

Coast Life
CHIROPRACTIC | LASER THERAPY

Please tell us about yourself

Dr/Mr/Mrs/Ms _____
(Family Name) (First Name) (Middle Init.)

Address: _____
(Street Address) (City) (Postal Code)

Telephone Number: _____ // _____
(Home) (Cell)

Emergency Contact: _____
(Name) (Relationship) (Phone #)

B.C. Health Care Number: _____

Date of Birth (mmm/dd/yyyy): _____ // Age: _____

Email (for appointment reminders): _____

Have you ever received any of the following therapies before?

Therapy	Name of Provider/Clinic	City & Year
☐ Chiropractic		
☐ Acupuncture		
☐ Massage		
☐ Physiotherapy		

Family Medical Doctor's Name: _____ // Clinic: _____

Date of Last MD Visit: _____ // Reason: _____

Communication between healthcare providers can greatly improve the quality and safety of your care. Do you consent to allow your health care provider at Coast Life Chiropractic to contact your medical doctor about your health care?
☐ YES ☐ NO Signature: _____ // Date: _____

Is this a WorkSafe BC Case? ☐ YES ☐ NO // Has your employer been notified? ☐ YES ☐ NO

If YES, Employer: _____ // Address: _____

Is this an ICBC case? ☐ YES ☐ NO // Date of Accident: _____ Claim #_____

How Did You Find Us? ☐ Referred by Medical Doctor ☐ Internet/Website ☐ Street Sign
☐ Referred by Friend/Family: _____ ☐ Other:_____

I realize that my Insurance (Public or Private) may not cover 100% of the Doctor's recognize fee schedule and that I am responsible for full payment of said fees up front, to be provided with a receipt after payment.

Signature: _____ // **Date:** _____

Patient Symptom Diagram

Coast Life CHIROPRACTIC | LASER THERAPY

Name: _____ **Date:** _____

INSTRUCTIONS:

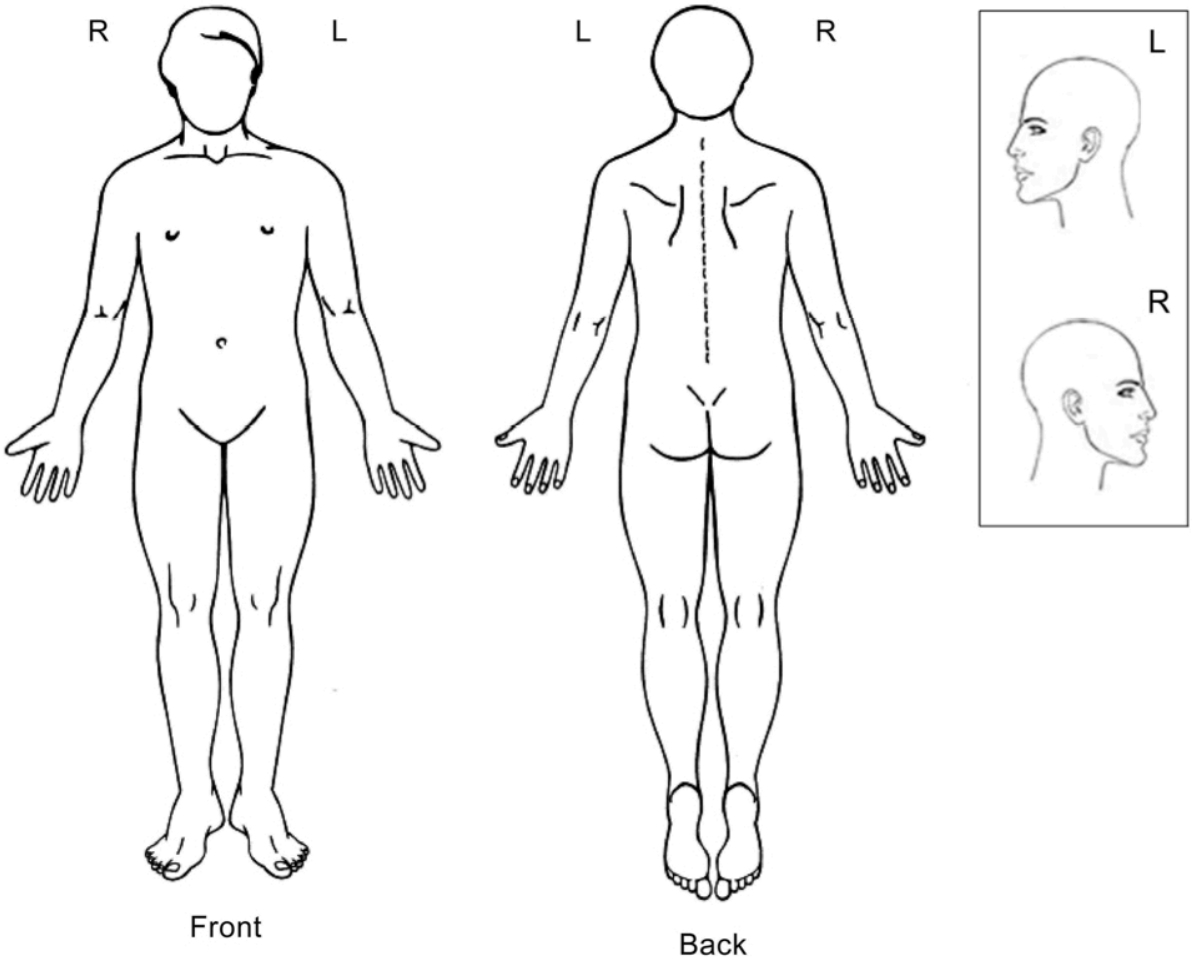
1) Please state your primary complaint: _____

2) Any recent accidents, injuries or surgeries? ☐ NO ☐ YES // If YES, Date: _____

3) Please draw a face on the diagram below.

4) Please use the symbols provided below to mark all of the areas on the diagram below that best represent ALL of the pain or sensations you are experiencing.

Numbness	====	Pins/Needles	~~~~	Burning	oooo
Sharp	xxxx	Dull/Achy	ΔΔΔΔ	Stiff/Tight	2222



Health Status Survey

Name: _____

Date: _____

Please check the box for any conditions or symptoms that are currently causing you problems.

General Symptoms	Muscle & Joint	Skin
❑ Loss of consciousness	❑ Neck pain/stiffness	❑ Rashes or itching
❑ Blackouts	❑ Mid back pain/stiffness	❑ Bruise easily
❑ Headache	❑ Low back pain/stiffness	❑ Dry skin
❑ Fever	❑ Tailbone pain	❑ Hives (allergies)
❑ Excessive sweating	❑ Shoulder/Arm pain	**Gastrointestinal**
❑ Night sweats	❑ Elbow pain	❑ Poor appetite
❑ Loss of weight	❑ Wrist/Hand pain	❑ Indigestion
❑ Night pain	❑ Hip/Groin pain	❑ Excessive hunger
❑ Generalized pain	❑ Knee/Leg pain	❑ Belching or gas
❑ Nervousness	❑ Ankle/Foot pain	❑ Vomiting
❑ Convulsions	❑ Arthritis	❑ Pain over stomach
❑ Loss of sleep	❑ Muscle weakness	❑ Constipation
Neurologic Symptoms	**Cardiovascular**	❑ Diarrhea
❑ Dizziness	❑ High blood pressure	❑ Jaundice
❑ Fainting	❑ Chest pain	❑ Ulcer
❑ Problems speaking	❑ Previous stroke	❑ Diabetes
❑ Problems swallowing	❑ Previous heart attack	**Genitourinary**
❑ Blurred vision	❑ Angina	❑ Trouble urinating
❑ Double vision	❑ Swelling around ankles	❑ Blood in urine
❑ Nausea	❑ Poor circulation	❑ Kidney infection
❑ Clumsiness	❑ Varicose veins	❑ Bedwetting
❑ Numbness or tingling	❑ Bleeding disorder	❑ Prostate trouble
Eyes/Ears/Nose/Throat	**Respiratory**	**GU for Women**
❑ Worsening vision	❑ Asthma	❑ Painful menstruation
❑ Eye pain	❑ Chronic cough	❑ Excessive flow
❑ Worsening hearing	❑ Spitting up phlegm	❑ Hot flushes
❑ Earache	❑ Spitting up blood	❑ Irregular/absent cycle
❑ Ringing/Buzzing in ears	❑ Difficulty breathing	❑ Cramping/backache
❑ Sinus pain/infection		❑ Vaginal discharge
❑ Frequent colds		❑ Swollen/painful breasts

Have you ever had a fracture or dislocation? ❑ No ❑ Yes; Where?	Birth control pill or patch usage? ❑ No ❑ Yes (previous) ❑ Yes (current) # of pregnancies _____ || # of children _____
Have you ever been in a car accident? ❑ No ❑ Yes; When?	Are you currently a smoker? ❑ No ❑ Yes; # packs/day: _____ Did you smoke previously? ❑ No ❑ Yes
Have you ever been hospitalized? ❑ No ❑ Yes; When? Why?	Please list any medications/supplements:
Have you ever been diagnosed with: Cancer? ❑ No ❑ Yes Hepatitis A/B/C? ❑ No ❑ Yes HIV/AIDS? ❑ No ❑ Yes	

Confidentiality of Information

Privacy Code
Privacy of personal information is important to Coast Life Chiropractic. We are committed to the collection, use and disclosure of this information in a responsible way. We will also try to be open and transparent as to how we handle your personal information.

Personal Information
Generally, the information we collect is limited to your name, home contact information, gender and age. As part of your patient file we retain your health history; health measurements and examination results; health conditions, assessment results and diagnosis; the health services provided to you or received by you; your prognosis and other opinions formed; compliance with treatment; and the reasons for your discharge and discharge recommendations. We also maintain records for payment and billing purposes. We only share your information with your consent; the use, retention and destruction of your personal information complies with the standards of our regulatory body, the College of Chiropractors of British Columbia, and the law.

Staff Members
Staff members who come into contact with your personal information are trained in the appropriate uses and protection of your information. These individuals include the clinic administration, the professionals and assistants that provide you with healthcare services and, when necessary, authorized individuals who may inspect our records as part of the regulatory activities in the public interest.

Disclosure of Personal Information
Our clinic understands the importance of protecting your personal information. To help you understand how we are doing that, below we have outlined how our clinic uses and discloses this information:

- To deliver safe and effective patient care
- To enable us to contact you
- To communicate with other healthcare providers
- To comply with legal and regulatory requirements
- To process payments and collect unpaid accounts
- For research purposes

By signing the consent section of this form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed in this code. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance.

Patient Consent
I have reviewed the above information that explains how Coast Life Chiropractic will use my personal information. I know that Coast Life Chiropractic has a Privacy Code and I may ask to see it at any time.

I agree that Coast Life Chiropractic can collect, use and disclose my personal information as set out above in the Clinic's privacy code.

_____ _____
(Signature) (Date)

_____
(Print Name)