SPECS AND SPINES
OPTOMETRY & CHIROPRACTIC

Dr. Ivan Koh
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To help us provide highest quality care, please fill out this form and submit at your appointment
ALL PERSONAL AND HEALTH INFORMATION IS CONFIDENTIAL

PATIENT HEALTH RECORD

Name: ____________________________ Date: __________________________

Address: _____________________ City: ________________ Postal Code:___________

Home: _______________ Business: ______________ Mobile/Cell: _________________

E-Mail: _____________________________

Date of Birth: (D/M/Y) ________________ Age: ______ Gender: M/F

Marital Status: __Single __Married __Divorced __Widow/er Children: Y/N

Employer: ___________________ Occupation: _________________ # of Yrs: ___

Emergency Contact: ______________________________ Phone #: ______________

Family Physician: ______________________________ Phone #: ______________

Who recommended our services to you? ____

Have you ever been hospitalized for anything other than surgery?

____

List all surgeries, accidents and falls: ____

____

Are you taking medication for: (check off all that apply)

Nerves/Stress	Energy	Blood Thinners
Pain	Blood Pressure	Muscle Relaxants
Heart	Cholesterol	Other

Is this consultation a result of:

MVA (motor vehicle accident) Y/N
Work Place Injury (WSIB) Y/N

Have you tried any treatments for your pain? Mark which apply and when.

	When?	Very Helpful	Helpful	No Benefit	Worse
Chiropractic					
Physiotherapy					
Massage					
Acupuncture					
Surgery					
Consultations					
Other					

Have you ever had previous Chiropractic/Acupuncture/Orthotic care? Y/N

If Yes, When: ________________ Dr. ______________________

What is the reason for your consultation?

____

What are your goals for treatment at this office?

____

What makes your condition worse: ____

What makes your condition better: ____

Previous diagnosis/treatment for condition: _____________________________________

Is your pain:

Improving Staying the same Getting worse

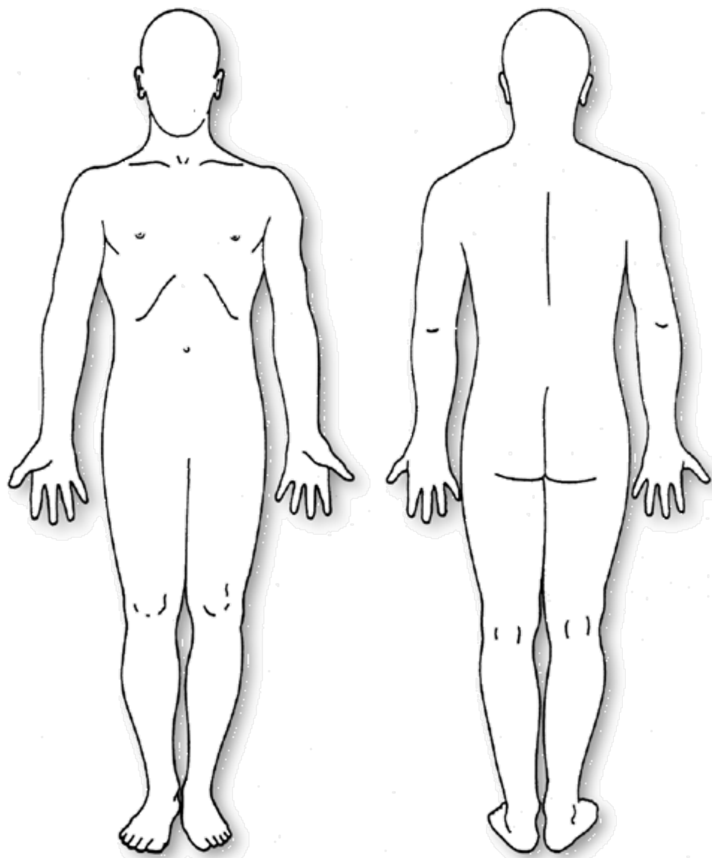
Pain at rest (please circle applicable number)

No pain 0___1___2___3___4___5___6___7___8___9___10____ Worse possible pain

Pain with activity (please circle applicable number)

No pain 0___1___2___3___4___5___6___7___8___9___10____ Worse possible pain

Mark the area (s) on the body where you feel the discomfort. Use the appropriate symbols. Include all affected areas.



Numbness	^^^^^ ^^^^^ ^^^^^
Pins and needles	0000 0000 0000
Burning	XXXX XXXX XXXX
Aching	****** ****** ******
Stabbing	/ / / / / / / / / / / / / / /

FAMILY HEALTH BACKGROUND: Many health issues may be hereditary, therefore we ask for information in regards to your family members. This will allow the doctor to have a better picture of your overall health. Please list family members who have/had any health issues.

Name Relationship Past and Present Health Issues

____

____

NUTRITIONAL & ACTIVITY INFORMATION:

Do you consume alcohol? Yes No

Do you smoke? Yes No

Allergies Yes No

Rate your diet: Poor Fair Average Good Excellent

Do you exercise: Yes No

If yes, what activities do you do? ______________________________________

PLEASE CIRCLE ANY CONDITIONS YOU HAVE BEEN TREATED FOR:

Arteriosclerosis	Alcoholism	Appendicitis	Arthritis
Anemia	Cancer	Diabetes	Diphtheria
Eczema	Cold Sores	Stroke	Fever Blisters
Mumps	Measles	Epilepsy	Ulcers
Heart Disease	Polio	Pneumonia	Tuberculosis
Venereal Disease	Rheumatic Fever	HIV/AIDS	

HAVE YOU EVER:	**Yes**	**No**
Used a cane, crutch or other support?	___	___
Been treated for a spine or nerve disorder?	___	___
Had a fractured bone?	___	___

FOR WOMEN ONLY:

Date of last menstrual cycle _____________ Are you pregnant? Yes No Maybe

I understand that my personal information will be kept confidential in accordance with The Registered Health Practitioners Act and Privacy Legislation.
I understand that for the purposes of communication between our office and the patient we will periodically send emails.

To opt out of email option, please check this box

_________________________ _________________

Patient Signature **Date**

Signature of Treating Doctor _________________________