

Kilian Chiropractic

555 Burrard St. Unit 205
Bentall Centre Underground Mall
604-688-0724
info@kilianchiropractic.com

Easiest way to find our office:

Enter the Bentall Centre at the corner of West Pender and Burrard Street. Go down the escalator. Kilian Chiropractic is straight ahead (20 meters)

My Appointment: _____

Patient History

Name: _____ Date: _____

Address: _____ City: _____

Prov.: _____ Postal Code: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Email: _____

Birth Date: (D/M/Y) _____ / _____ / _____ Gender: Male or Female

Occupation: _____ Spouse: _____

How did you hear about our office? _____

Do you have extended health care benefits? Yes No *If yes, please find out the details before your next visit.*

What is your chief complaint - the reason you came to Kilian Chiropractic?

Do you experience: Neck Pain? Mid Back Pain? Low Back Pain? Headaches?

How long have you been tolerating your main complaint? _____

Have you had this problem in the past? Yes No If yes, when? _____

Have you seen other practitioners for this problem? Yes No

If yes, whom? (circle all that apply)

Chiropractor Massage Naturopath Acupuncture TCM Medical Doctor

Neurologist Orthopedist Personal Trainer Physiotherapist

What makes the problem worse? _____

Do you experience tingling, numbness or pain travelling down your:

Arms? Yes No Legs? Yes No

What is the severity of pain on a scale of 1/10: Today? _____ /10 At its worst? _____ /10

How long ago was it at its worst? _____

When does pain occur? AM PM Varies All Day

What specific activities does it interfere with? (work, sleep, leisure, sleeping, driving, etc.)

Have you lost time from work because of it? Yes No If yes, when? _____

Do you "crack" your own (circle which apply): Neck Mid Back Low Back

Rate your level of commitment to resolving this/these problems. (10 being the highest)

1 2 3 4 5 6 7 8 9 10

On the diagram below, show where you are experiencing all of your present complaints using the following letters:

● A: Aching

● B: Burning

● C: Cramping

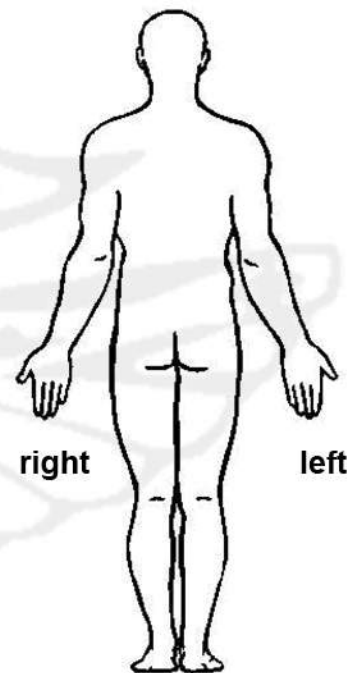
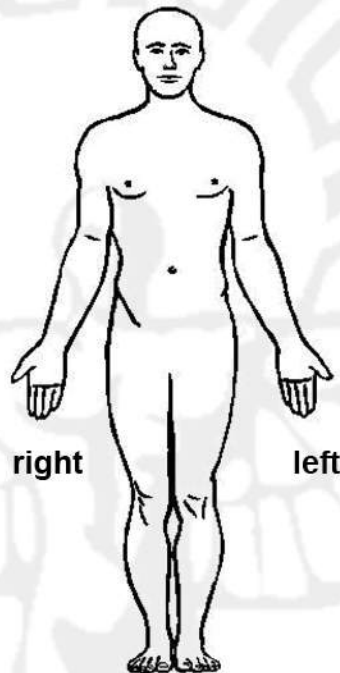
● D: Dull

● Tl: Tight

● N: Numbness or Tingling

● TH: Throbbing

● S: Stiff



List all Motor Vehicle Accidents you have had (approximate dates and severity):

List all past impacts, hard falls, sports injuries, concussions, broken bones, etc. (approximate dates and severity):

How many hours a day do you spend sitting? (work, travel, and home total) _____

List any type of exercise you do and frequency per week: _____

List all medication you are currently taking: _____

List all major surgeries you have had (approximate dates): _____

Do you have a family history of: Arthritis Cancer Heart Disease Diabetes

Are you pregnant? Yes No If yes, when is your due date? _____