



Okanagan Chiropractic Corp
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www.OkanaganChiropractic.Com

Dr. Troy Wielgosz
2640 Pandosy St
Kelowna BC

CASE HISTORY

Name _____ Date _____ BC Medical # _____
Address _____ City _____ Province _____
Postal Code _____ Phone (Home) _____ (Cell) _____
Email _____ Date of Birth _____ Sex: M F
Marital Status: S M D W Spouse's Name _____
If minor, parents name _____
Children's names _____
Family Doctor: _____ Phone: _____
Occupation: _____ Present condition due to an injury? ___ No ___ Yes
On the Job ___ Auto Accident ___ Other _____
Has the accident been reported? ___ No ___ Yes ___ to: WCB ___ ICBC ___ Other _____
If yes, claim number _____
Who can we thank for this referral? _____

STOP!! PLEASE READ!!!

The purpose of today's visit is to provide the most complete chiropractic examination that most people have ever had. **ONLY in EXCEPTIONAL circumstances will any adjustments be performed** prior to your file being carefully analyzed and the findings presented. This approach is consistent with any significant health-related procedure. You will find that the two things we will never compromise are YOUR HEALTH and OUR REPUTATION. **PLEASE INITIAL HERE indicating that you have read and understand this section:** _____

HEALTH REPORT

Reason for seeking care: _____
How long has this been a problem: _____ List any other doctors seen for this: _____
List any diagnosis and type of treatment: _____
Have you had X-rays in the past year? ___ No ___ Yes. If yes, do you have a copy _____
What do YOU believe is the cause of the complaint: _____
Have you had similar conditions before? ___ No ___ Yes If yes, explain: _____
Are there any significant illnesses or Conditions in your family? _____
Have you had previous chiropractic care? ___ No ___ Yes
If yes, reason(s) for not continuing your care _____
Have you been treated for any health condition by a physician in the last year? ___ No ___ Yes
If yes, explain: _____
Any significant MVA or Injuries? _____

Are you currently taking medication? No Yes. If yes what medications: _____

List the approximate dates of any surgery or treated conditions: _____

Do you have any secondary health complaints you would like to address with Dr. Troy?

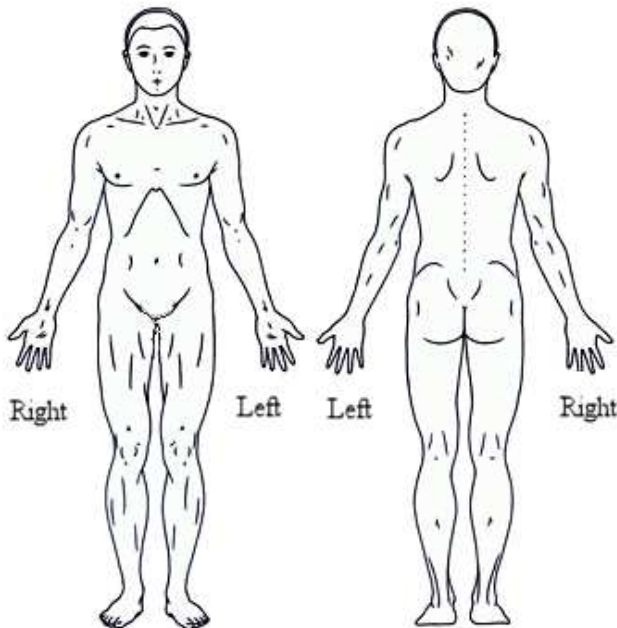
Social Report

Do you smoke Y/N •Alcohol Y/N Daily Weekly Socially •Caffeinated drinks per day _____

Do you take Vitamins/Supplements No Yes If yes, type and how often _____

Do you play any sports? No Yes If yes which ones _____

Have you been able to continue with your sporting activities? No Yes



Please circle degree of pain, 0 none, 10 severe pains.

0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.

Numbness	===
Dull Ache	OOO
Burning	XXX
Sharp/Stabbing	///
Pins, Needles	+++
Other _____	^^^

What activities aggravate your condition/pain? _____

What activities lessen your condition/pain? _____

Is this condition worse during certain times of the day? Yes No

If yes what times of day _____

Is this condition interfering with: Work Yes No; Sleep Yes No; Routine Yes No

Other Yes No, Please Explain _____

Is this condition progressively getting worse? Yes No

*Females Only: Are you pregnant? Yes No

The average person understands that it takes time to get out of shape, and it takes time to get back into shape. To think an out-of-shape person can exercise tonight and be in shape tomorrow is unrealistic. Removing layers of spinal injury is a process, not a quick fix.

What's holding you back?

- 1. Do you miss out on sports or physical activities as a result of your pain? Y/N**
- 2. Are you worried about what the diagnosis might be if you visit a health professional? Y/N**
- 3. Do you feel you are too busy to seek proper treatment for your pain? Y/N**
- 4. Are you eating as healthy as you could be? Y/N**
- 5. What lifestyle habits are you not willing to give up? _____**
- 6. What is your stress level: 1 being good 10 being horrible _____**

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand that it is my responsibility to inform this office of any changes in my health.

I agree to allow this office to examine me for further evaluation. This information will be used to assist the doctor in making the best choices for your examination AND for

Deciding how chiropractic care can best help you. The information collected **will be kept confidential** and will only be used for clinical purposes. It **WILL NOT** be shared with anyone else without YOUR express permission.

Patient Signature _____ Date _____