Dr. Davis E. Lindsay, B.Sc., D.C. "Transforming Lives!"

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□CONFIDENTIAL PRACTICE MEMBER CONSULTATION FORM

Name: ____
(First) (Middle) (Last)

Salutation: Mr. □ Mrs. □ Miss □ Ms.□ Dr. □

Marital Status: Single □ Married □ Divorced □ Widowed □ Separated □ Com Law □

Address: ____

City: ____________________ Postal code: ____________________

Phone: (C)________________(W): ________________ (H): ________________

To receive appointment reminders by text include your cell provider ________________

Care Card Number: ____________________ Birthdate: ________________
(mm/dd/yyyy)

Email Address: ____

Occupation: ____________________ Employer: ____________________

Family Medical Doctor: ____

Emergency Contact Person: ____________________ Phone # ____________

Referred By: ____

Is this a: WCB Claim □ ICBC Claim □

1) What is your main health concern? ____

____

2) Please describe what it feels like ____

3) What makes it worse? ____

4) What makes it better? ____

5) When did this condition first begin? ____

6) Have you experienced this problem(s) before? ____

7) Is this problem getting progressively: Better □ Worse □ No Change □

8) What do you feel is the cause of this problem? ____

9) Are you receiving any treatment for this condition? YES □ NO □
If yes, what type: ____

10) Have you ever received Chiropractic care? YES ☐ NO ☐
If yes, when: ______________________________

11) Please list your past surgical and dental surgeries including the approximate date of each:
____

12) List any Motor Vehicle Crashes (Fender Benders), broken bones, or hospitalizations (include year):
____

13) List Prescription and Non Prescription Medications (includes birth control) you take:
____

14) List nutritional supplements (vitamins) you take: ______________________________

15) Do you regularly use any of the following and how often:
sugar ☐ cigarettes ☐ coffee ☐ alcohol ☐ drugs ☐ soda pop ☐

16) Please list all food and beverages you ate yesterday.

Breakfast ______________________________
Lunch ______________________________
Supper ______________________________
Snacks______________________________

17) List any infectious and/or serious diseases and when:
____

18) Do you have any children and if so how many? ______________________________

19) Please give a brief overview of any serious illness that runs in your family ______________
____

21) Has this problem affected your ability to:
Work? ☐ Sleep? ☐ Do household chores? ☐ Participate in recreational activity? ☐

22) What do you want to be able to do again that you are not able to do now? ______________
____

23) What is your typical sleeping position? ______________________________

24) Have you had any severe emotional stress or trauma? ______________________________

25) Is there any other information concerning your health or lifestyle, you feel is relevant? __________
____

Have you had any of the following? Please Check:

aneurysm ☐ cancer ☐ epilepsy ☐ stroke ☐ allergies/asthma ☐ hepatitis ☐ depression ☐
fatigue ☐ sleeping difficulty ☐ sinus conditions ☐

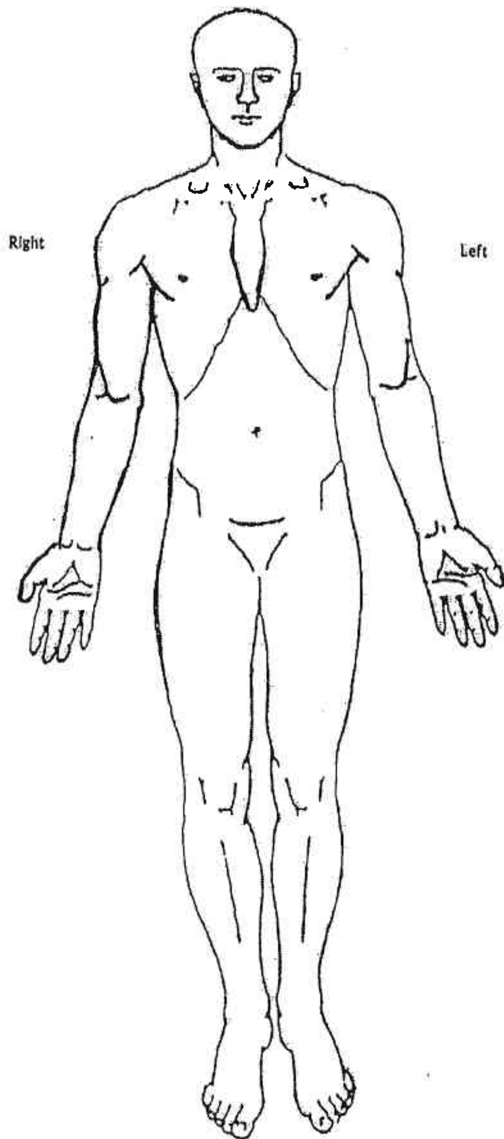
Patient Signature ______________________________**Date**______________

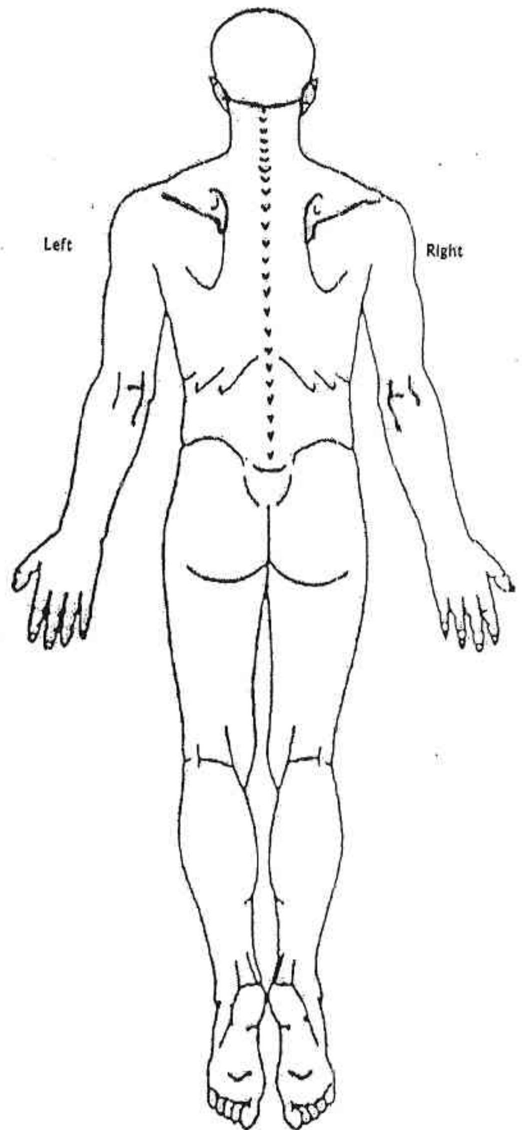
Body Diagram

Please use the following symbols to show exactly where you have pain:

SSS Sharp pain
DDD Dull ache
BBB Burning pain
NNN Numbness
TTT Tingling or pins and needles

If symptom is intense or constant, use 3 letters; if slight or occasional use one letter; if in between, use 2.





Patient Signature ______________________________ Date ____________________

(Signature of parent if the patient is a minor)

LIFE IMPACT

Patient Name________________ Date________________

☐ AM ☐ EX ☐ AN ☐ DR

Which of these five categories in your life is impacted most by your symptom/s?

☐ Work ☐ Relationships ☐ Recreational Activity ☐ Household Chores ☐ Sleep

WORK – What is your primary function at work?________________

- Has this ______ pain affected that function? "Yes",how?________________
- Has this ______ pain caused you to miss any work at this point? "Yes", how much________ When?________
- Has this ______ pain kept you from producing quality work. "Yes",describe________________
- Has this ______ pain stopped you from finishing all your job duties? "Yes", explain: ________________
- If no, ask would you rather go to work with or without this ______ pain? "Without"-then this ______ pain is affecting your job.

RELATIONSHIPS – What primary activities are you involved in with your:

- Spouse? ________________
- Children? ________________
- Friends? ________________
    - Has this ______ pain affected these activities with your:

Spouse?, "Yes", how?________________
Children?, "Yes", how?________________
Friends, "Yes", how? ________________

- If no, ask would you rather spend time with your spouse/children/friend with or without this______ pain? "Without" – then this ______ pain is affecting your relationships.

RECREATIONAL ACTIVITIES – What primary recreational activities are you involved in?________________

- Has this ______ pain kept you from ______ at this point? "Yes", explain ________________
- Has anyone commented on your performance in ______ since suffering with this ______ pain?
- If no, would you rather ______ with or without this ______ pain? "without" – Then this ______ pain is affecting your recreational activity.

HOUSEHOLD CHORES –What are your main household chores?________________

- Which household chore has this ______ pain affected most? ________ How? ________________
- Have you had to get help from family members or hire someone to assist with household chores at this point? "Yes", which chores? ________________
- If no, would you rather perform household chores with or without this ______ pain. "Without" – Then this ______ pain is affecting your household chores.

SLEEP

- Has your sleep been affected by this pain?________________ How? ________________