



Personal Health Profile

SECTION 1 – YOUR IMPORTANT BACKGROUND INFORMATION

IMPORTANT: Please complete each and every question as honestly and as accurately as possible. The quality of your responses will affect our ability to help you with your health concerns.

Today's Date: _____

Your present Age: _____

Name: _____
First Middle Last Suffix (Jr, Sr, MD, JD, DC, PhD)

By what name would you like to be addressed? _____

Gender: Female Male Date of Birth: _____ Height: _____ Weight: _____

Address: _____

City Prov Postal Country

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Best phone number to reach you: Home Work Cell

Preferred Email Address: _____ (Your email will not be sold or shared in any way)

Marital status: Married Single Single and living with partner Divorced Separated Widowed

How are you completing this questionnaire? On my own Someone else is assisting me

Please name the person assisting you: _____

Emergency Contact: _____
First Last Relationship to you
Relationship: _____

Emergency Phone: (_____) _____ First Name Last Name Alternate Phone: (_____) _____

REFERRAL INFORMATION

How were you referred to our center? Friend Physician Colleague Relative Website Other: _____

Referring person's name: _____ Specialty: _____

Phone No. (If physician): _____

SYSTEMS REVIEW: PLEASE READ AND ANSWER EACH OF THE FOLLOWING IMPORTANT QUESTIONS

1. I have Osteoporosis Yes No Not Sure If yes, explain: _____
2. I have a Pace Maker Yes No Not Sure If yes, explain: _____
3. I have / had Aneurysm/s Yes No Not Sure If yes, explain: _____
4. I have Lupus Yes No Not Sure If yes, explain: _____
5. I have Rheumatoid Arthritis Yes No Not Sure If yes, explain: _____
6. I have Psoriatic Arthritis Yes No Not Sure If yes, explain: _____
7. I have an Anxiety Disorder Yes No Not Sure If yes, explain: _____
8. I am frequently Dizzy Yes No Not Sure If yes, explain: _____
9. I have had spinal surgery Yes No Not Sure If yes, explain: _____
10. Have rods or devices in spine Yes No Not Sure If yes, explain: _____
11. I am Diabetic Yes No Not Sure If yes, explain: _____
12. On Blood Thinning medication Yes No Not Sure If yes, explain: _____
13. I Have / had cancer Yes No Not Sure If yes, explain: _____
14. Knee / Hip Replacement Yes No Not Sure If yes, explain: _____
15. I had Shoulder Surgery Yes No Not Sure If yes, explain: _____

PRIOR CARE: PLEASE LIST ANY THERAPIES THAT YOU HAVE TRIED BEFORE (INCL. RESULTS)

1. Physical Therapy Haven't tried Very Helpful Helped a little Did not help Hurt worse
2. Chiropractic Haven't tried Very Helpful Helped a little Did not help Hurt worse
3. Acupuncture Haven't tried Very Helpful Helped a little Did not help Hurt worse
4. Over counter meds Haven't tried Very Helpful Helped a little Did not help Hurt worse
5. Epidural Haven't tried Very Helpful Helped a little Did not help Hurt worse
6. Prescribed Medication Haven't tried Very Helpful Helped a little Did not help Hurt worse
7. Decompression Therapy Haven't tried Very Helpful Helped a little Did not help Hurt worse
8. Spinal Traction Haven't tried Very Helpful Helped a little Did not help Hurt worse
9. Massage Haven't tried Very Helpful Helped a little Did not help Hurt worse
10. Other: _____ Haven't tried Very Helpful Helped a little Did not help Hurt worse

MEDICATIONS: PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING OR ATTACH A LIST

Medication	Strength	Frequency	Medication	Strength	Frequency

ALLERGIES: PLEASE LIST ALL ALLERGIC REACTIONS THAT YOU ARE AWARE OF

Drug Allergy	Reaction

TESTING: PLEASE LIST ALL TESTS THAT HAVE BEEN PERFORMED ON YOU DURING THE PAST YEAR

SOCIAL / PERSONAL HISTORY

Test	Yes	No	Result, if known
MRI			
CT Scan			
X-Ray			
EMG			
Bone Scan			
Blood Test			
Other:			

Occupation: _____

Are you still working? Yes No

Children: Yes # _____ No

Do you smoke? Yes # _____ No

WOMEN

Drink alcohol? Yes # _____ No

Are you pregnant? Yes No

Drink caffeine? Yes # _____ No

Last menstrual period date: _____

Family Medical History	Major Illnesses
Father / Living <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mother / Living <input type="checkbox"/> Yes <input type="checkbox"/> No	
# of Brothers _____	
# of Sisters _____	

ALL PATIENTS PLEASE READ AND SIGN THE FOLLOWING:

I hereby certify that I have read each question contained in this questionnaire. I furthermore guarantee that I have answered all questions honestly and accurately, to the best of my knowledge. I understand and acknowledge that any omission or misrepresentation in this document can seriously jeopardize the ability of the physicians and therapists at the BC Back Institute, to assist me. I understand that such omissions and misrepresentations may in fact endanger me and my health. I hereby give my permission for all staff at the aforementioned center to review my responses to this questionnaire.

Signed: _____ Date: _____

Checked for completeness by: _____

Reviewed: _____

Date: _____

OFFICE USE ONLY: