grandview health group ltd.
#205-2411 160th St. Surrey, BC
778-294-0944

Last name: ______________________________**First name:** _________________________ Date_______________

Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Other

Name I prefer to go by: _____________________________ **Care card**#________________________________

Birthdate: ________________________________ Age: ______ Male ☐ Female ☐

Address: ____ **City**:______________________________

Postal Code: ___________________

Home phone:___________________ **Cell phone**:___________________ **Work phone**:__________________

Email address:____

How did you hear about us?____

Occupation:_________________________________ Employer: ____

Student: ☐ Full time ☐ Part time School:____

Medical Doctor:_______________________________________ Phone Number: _____________________________
Reason for last visit: ____

Have you had previous care from . . . ☐ Chiropractor ☐ Massage Therapist ☐ Acupuncturist
Practitioner's Name: ____________________________________
Date of last visit: _______________________ X-rays taken: ☐ Yes ☐ No Date:_____________________

Spouse's Name:____ Number of Children __________________

Emergency contact:____ Phone:__________________________

Is this visit the result of a motor vehicle accident? ☐ Yes ☐ No
Is this visit the result of a work related injury/accident? ☐ Yes ☐ No

Please give a brief explanation of what you do, ie: sitting at desk, lots of heavy lifting

____

____

Please explain reason for visit: ____
____
____
____

Expectations/Goals: ____
____

Patient Name:________________________ Date:_________________

Please mark areas of injury or discomfort. Please indicate degree of pain on the pain scale below.

Numbness	Pins & Needles	Burning	Aching	Stabbing
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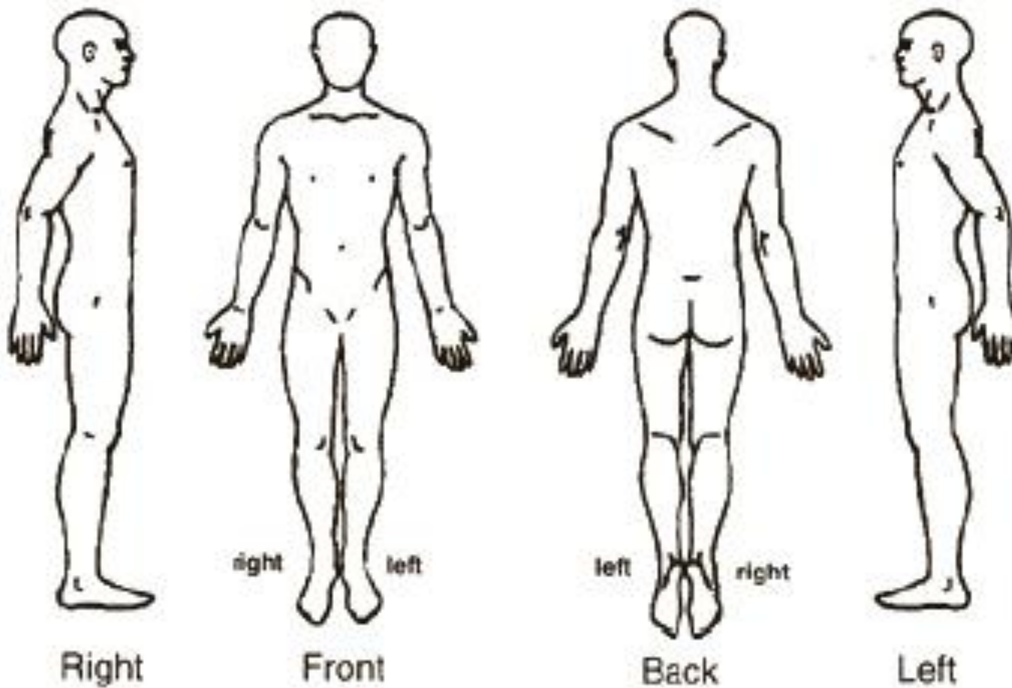

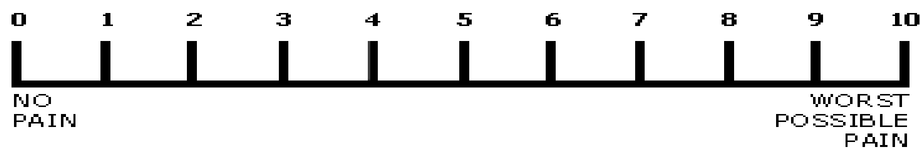

Do you smoke? ☐ Yes ☐ No Do you consume alcohol? ☐ Yes ☐ No Type: ________________________

Do you exercise? ☐ Yes ☐ No Number of hours per week:_____ Type of exercise:________________________

Falls and accidents:____

____

Surgeries:____

Surgeries recommended but not performed:____

Have you ever been knocked unconscious? ☐ Yes ☐ No ☐ Unsure

Hospitalizations:____

Does anyone in your immediate family suffer from the following conditions:

☐ Cancer ☐ Heart disease ☐ Diabetes ☐ Stroke ☐ Osteoporosis ☐ Other____________________

Please list medications that you take, the reason, and if it is taken on a regular basis:

Medication Name	Reason	Regular Basis
____________________	________________________________	☐ Yes ☐ No
____________________	________________________________	☐ Yes ☐ No
____________________	________________________________	☐ Yes ☐ No
____________________	________________________________	☐ Yes ☐ No
____________________	________________________________	☐ Yes ☐ No

Please list any minerals or supplements that you take and if they are taken on a regular basis:

Supplement Name	Regular Basis	Supplement Name	Regular Basis
____________________	☐ Yes ☐ No	____________________	☐ Yes ☐ No
____________________	☐ Yes ☐ No	____________________	☐ Yes ☐ No
____________________	☐ Yes ☐ No	____________________	☐ Yes ☐ No

Please check the appropriate box for any of the following symptoms which you now have or have had previously.

C= Current **P= Past**

C P

☐ ☐ allergy
☐ ☐ chills
☐ ☐ convulsions
☐ ☐ dizziness
☐ ☐ fainting
☐ ☐ fevers
☐ ☐ headaches
☐ ☐ loss of sleep
☐ ☐ nervousness
☐ ☐ depression
☐ ☐ neuralgia
☐ ☐ numbness
☐ ☐ sweats
☐ ☐ loss of weight
☐ ☐ tremors

MUSCLE AND JOINT

☐ ☐ arthritis
☐ ☐ bursitis
☐ ☐ foot trouble
☐ ☐ hernia
☐ ☐ low back pain
☐ ☐ neck pain
☐ ☐ neck stiffness
☐ ☐ pain between shoulders

RESPIRATORY

☐ ☐ chest pain
☐ ☐ chronic cough
☐ ☐ difficulty breathing
☐ ☐ spitting blood
☐ ☐ throat phlegm
☐ ☐ wheezing

EYES, EARS, NOSE & THROAT

☐ ☐ colds
☐ ☐ crossed eyes
☐ ☐ deafness
☐ ☐ dental decay
☐ ☐ asthma
☐ ☐ ear aches
☐ ☐ ear discharge
☐ ☐ ringing in ears
☐ ☐ sinus infections
☐ ☐ enlarged glands

C P

☐ ☐ enlarged thyroid
☐ ☐ sore throats
☐ ☐ tonsillitis
☐ ☐ eye pain
☐ ☐ failing vision
☐ ☐ far sighted
☐ ☐ gum trouble
☐ ☐ hay fever
☐ ☐ hoarseness
☐ ☐ nasal obstruction
☐ ☐ near sighted
☐ ☐ nose bleeds

CARDIOVASCULAR

☐ ☐ rapid heart beat
☐ ☐ slow heart beat
☐ ☐ swelling of ankles
☐ ☐ hardening of arteries
☐ ☐ high blood pressure
☐ ☐ low blood pressure
☐ ☐ pain over heart
☐ ☐ poor circulations

GASTROINTESTINAL

☐ ☐ excessive hunger
☐ ☐ burping or gas
☐ ☐ liver trouble
☐ ☐ colitis
☐ ☐ diarrhea
☐ ☐ difficult digestions
☐ ☐ distention of abdomen
☐ ☐ hemorrhoids
☐ ☐ intestinal worms
☐ ☐ jaundice
☐ ☐ poor appetite
☐ ☐ nausea
☐ ☐ vomiting
☐ ☐ vomit blood

SKIN

☐ ☐ boils
☐ ☐ bruise easily
☐ ☐ dryness
☐ ☐ hives or allergies

C P

☐ ☐ itching
☐ ☐ skin rash
☐ ☐ varicose veins

GENITO-URINARY

☐ ☐ bed wetting
☐ ☐ blood in urine
☐ ☐ frequent urination
☐ ☐ loss control urine
☐ ☐ kidney infection
☐ ☐ painful urination
☐ ☐ prostate trouble
☐ ☐ pus in urine
☐ ☐ smell of urine

PAIN OR NUMBNESS IN…

☐ ☐ shoulders
☐ ☐ arms
☐ ☐ hands
☐ ☐ hips
☐ ☐ legs
☐ ☐ knees
☐ ☐ ankles
☐ ☐ feet
☐ ☐ painful tail bone
☐ ☐ sciatica
☐ ☐ swollen joints

FOR WOMEN ONLY

☐ ☐ cramps
☐ ☐ heavy flow
☐ ☐ light flow
☐ ☐ irregular cycle
☐ ☐ painful cycle
☐ ☐ discharge
☐ ☐ sore breasts

Menopausal ☐ YES ☐NO
Last menstruation date: ____________________

Pregnant ☐ YES ☐ NO
Due Date:________________

Hysterectomy ☐ YES ☐ NO

I affirm that all information on this form are true and correct to the best of my knowledge.
I understand that I am responsible for all visit charges at this office.

I understand there is a 24 hour cancellation policy and that I may be charged for last minute cancellations.

Patient Name (please print):____

Patient Signature:____ **Date:**______________________________