# BENEFIT CHIROPRACTIC & WELLNESS

**1 – 20571 Douglas Crescent, Langley, BC V3A4B6**
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**Dr. Ben Zerkee – Chiropractor**
**Dr. Andrew Erjavec – Chiropractor**

**Carl Pingul – RMT**
**Lois Griffey – RMT**
**Jay Lee – Acupuncture & TCM**

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## PERSONAL HISTORY

Name: _____ Birthdate: D/_____M/_____Y/_____

BC Health Card #_____Email (for email reminders)_____

Home Phone_____Cell Phone_____Work Phone_____

Address_____City_____Postal Code_____

Marital Status_____Children _____

Age_____Weight_____Height_____

Employer _____ Occupation _____Requires lifting?_____

In case of emergency who should we contact? _____ Phone_____

****Referred by:** ( ) Website ( ) Newspaper ( )Internet Search ( ) Phone Book ( ) Family Physician ( ) Relative/Friend ( ) Other

## CURRENT HEALTH CONDITION

Reason for visiting this office_____

Is this: ( ) **WCB** Claim ( ) **ICBC Claim** If Yes: Date of Injury : _____Claim #_____

Previous treatment for this condition: ( ) Chiropractor ( ) Massage ( ) Physiotherapist ( ) Other_____

When did this condition begin? _____Was it: ( ) Sudden ( ) Gradual ( ) Unknown

What do you believed caused this condition?_____

What aggravates your condition? ( ) Sitting ( ) Standing ( ) Bending ( ) Lifting ( ) Walking ( ) Other_____

What relieves your condition?_____

Have you had any time loss from work for this condition? (if recent, list dates)_____

Have you had any x-rays of the spine in the past 5 years?_____If yes, where?_____

Do you wear Orthotics?_____If yes, how old are they?_____

**Medications**: ( ) Anti-inflammatory ( ) Muscle Relaxants ( ) Pain Killers ( ) Heart Medications ( ) Blood Pressure ( ) Other_____

**Has anyone in your family had the following diseases?**

( ) heart disease ( )high blood pressure ( ) stroke ( )cancer ( )arthritis ( ) diabetes ( ) Other_____

Please **CHECK** any conditions which are **presently causing a problem**.

___ Low back problems
___ Pain between shoulders
___ Neck problems
___ Arm problems
___ Leg problems
___ Swollen joints
___ Pain/stiff joints
___ Sore muscles
___ Weak muscles
___ Walking problems
___ Disc hernia/bulge
___ Osteoporosis
___ Arthritis

___ Bladder trouble
___ Excessive urine
___ Excessive thirst
___ Nausea
___ Abdominal pain
___ Diarrhea / Constipation
___ Liver trouble
___ Weight trouble (large recent gain/loss)
___ Gall bladder trouble
___ Diabetes
___ Vision problems
___ Headaches

___ Ear Pain / Ringing in ear
___ Dental /Jaw problems
___ Chest pain
___ Pain over heart
___ Difficulty breathing
___ Persistent cough
___ Rapid heartbeat
___ Blood pressure problems
___ Stroke
___ Heart problems
___ Lung problems
___ Cancer

**OTHER SYMPTOMS/CONDITIONS**

_____

**FEMALES ONLY**
Are you pregnant?
___Yes ___No

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## PAST HEALTH HISTORY

**Major Surgery/Operations**: ( ) Appendix ( ) Tonsils ( ) Hernia ( ) Gall-Bladder

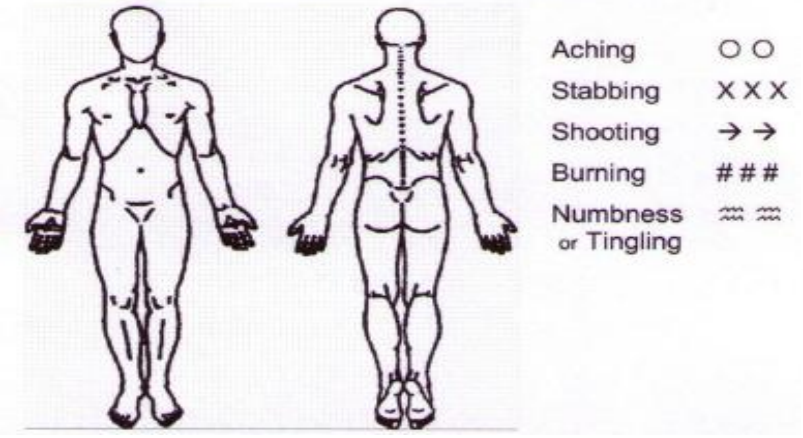
( ) Neck ( ) Back ( ) Shoulder/Arm ( ) Leg/ knee ( ) Other:_____

Major accidents or falls – car accidents? (please describe)_____

Have you had previous Chiropractic or Massage care?_____

**Family Physician** _____ **Phone Number**: _____

**Please indicate on the diagram the nature of your symptoms, using the symbols indicated:**




**Please Note:**
Your appointment has been reserved for you. In a courtesy of your doctor or therapists & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee may be charged.

**Payment for all treatments, whether private or insured, is ultimately the responsibility of the patient.**

We will assist you in billing MSP, ICBC, WCB or other agencies if possible, but please remember any payments not covered or rejected by these agencies are **your responsibility.**

**Signature:**_____ **Date:**_____