DR. KEVIN MCKENZIE
DR. STEVE FORTÉ

Suite 205-518 Lake Street, Nelson, B.C.
Phone 352-1322

Last Name:_____________________________ First Name:________________________ Initial:_____
MSP/Care Card #____________________________ E-mail Address____________________________
Date of Birth:___ ___ ___ Age:_____ Occupation:____
mo day yr
Address: ___________________________________ City:__ ______________ Postal Code:_______
Phone: (H) ____________ (W)____________ Sex: M F Marital Status S / M / D / W / CL
Spouse's Name: ____________________ # of children: _______ Medical Doctor: ____________
ICBC Claim # _________________ Work Injury? ☐ WCB Claim # ___________________
Whom may we thank for referring you to us?____
Reason for consulting our office:____
____

PLEASE CIRCLE OR FILL IN APPROPRIATE RESPONSES:

ONSET: How did this discomfort start? Sudden Gradual Unusual Activity
How long has it bothered you? days weeks months years Date of injury:
Cause of injury: ____
Have you had this problem before?____

PALLIATIVE: What have you done to help it feel better? Ice Heat Stretches/Exercise
Medication: _____________________________ Therapy:_______________________________
Other Health Practitioners you've seen? Chiropractor:_________________________________
Medical Doctor:____
Physiotherapist:____
Other:____

PROVOCATIVE: What aggravates or makes your problem worse?___________________________
____
____

Does it interfere with:
work sleep walking sitting hobbies leisure

What is the progress of your condition: Better Worse Same

Describe the quality of the discomfort:
Sharp Burning Dull Achy Tingling Numb Electric Throbbing Pinching
Shooting Constant Travels/radiates Comes and Goes
Other:____

How would you rate your level of discomfort or pain? Please mark an "X" on the line below
0____10
NO PAIN EXTREME PAIN

HISTORY:
Please fill in to the best of your ability anything appropriate to the following, whether you think they relate to your current condition or not:
Previous or Current Illness or Disease:____
____
____
Surgeries:____
____
Motor Vehicle Accidents:____
____
Other Accidents (Broken bones, Bad falls, etc)____
____
Mental/emotional stress:____
____
Hospitalized for any other reason____
For Mothers - any birth complications____

PLEASE TURN OVER

CURRENT MEDICATIONS:____
____

Please rate your use of:

Coffee:	none	light	moderate	heavy
Alcohol:	none	light	moderate	heavy
Tobacco:	none	light	moderate	heavy

Rate your stress (on a 1 - 10 scale): Occupational____ Personal____
(0=none 10=extreme)

Rate the Following: (circle)

Diet	poor	fair	good	excellent
Exercise	poor	fair	good	excellent
Sleep	poor	fair	good	excellent
Ability to relax	poor	fair	good	excellent
Energy Level	poor	fair	good	excellent
Overall Health	poor	fair	good	excellent

Do you take supplements? (Vitamins & Minerals) Yes No Occasionally
List any supplements you might currently take:____
____
What sports do you partake in?____
____
Please "circle" all symptoms you have ever had, even if they do not seem to relate to your current problem
Place an "X" beside symptoms you are experiencing currently.

Headache	Pins & needles in legs	Fainting	Neck pain
Loss of smell	Pins & needles in arms	Back pain	Dizziness
Loss of balance	Buzzing in ears	Ringing in ears	Nervousness
Numbness in fingers	Numbness in toes	Loss of taste	Stomach upset
Fatigue	Depression	Irritability	Tension
Sleeping problems	Neck stiff	Cold hands	Cold feet
Diarrhea	Constipation	Fever	Hot flashes
Cold sweats	Lights bother eyes	Heartburn	Problem urinating
Mood swings	Menstrual irregularity	Menstrual pain	Ulcers

You're done! The Doctor will cover the rest with you.

G.I.____
____

G.U.____
____

CARDIO____
____

RESP.____
____
E____
E____
N____
T____

N.S.____
____
CIRC.____
____
MUSCULO/SKELETAL____
____