Landmark
health

Dr. V.J. Leering
#200-1708 Dolphin Ave Kelowna BC V1Y 9S4 236.420.0620

PATIENT INTAKE FORM

Date:____________

Please fill out our confidential Patient Health Record completely and accurately.
If you have any questions, please don't hesitate to ask your practitioner.

IS THIS VISIT RELATED TO: ☐ **ICBC CLAIM** ☐ **RCMP**

PERSONAL INFORMATION

Legal Given Name: ________________________________

Surname: ________________________________

Preferred Name: ________________________________

Birthdate (mm/dd/yyyy): ________ /________ / ________

Age: ____________

Address: ________________________________

City: ______________ Prov: _____ Postal: __________

Occupation: ________________________________

Home #: ______________ Work #: ______________

Mobile #: ________________________________

Email: ________________________________

Emergency Contact: ________________________________

Phone #: ________________________________

Did a health care practitioner refer you?

Yes ☐ No ☐

If yes, please provide the following:

Name: ________________________________

Phone #: ________________________________

Current Medical Practitioner: ________________________

Phone #: ________________________________

Date of last physical examination? ____________________

Briefly describe your main concern(s):

____

____

Overall, how is your general health?

____

____

List of current medications:

____

____

REASON(S) FOR YOUR APPOINTMENT

Is the purpose of this visit appointment related to?

☐ Job Injury ☐ Auto Accident ☐ Fall Injury ☐ Sports Injury

☐ Chronic Discomfort ☐ Wellness Care ☐ Other

How long have you had this condition? ____________________

Is your condition getting: ☐ **worse** ☐ **better** ☐ **same**

What seems to make the condition **better**?

____

What seems to make the condition **worse**?

____

What have you tried that has **not worked**?

____

Is it interfering with your:

☐ Work ☐ Sleep ☐ Daily Routine ☐ Other

Have you seen a:

☐ Chiropractor ☐ Physiotherapist

☐ Massage Therapist ☐ Acupuncturist

Date of last treatment: ________________________________

Were you happy with the results? Yes ☐ No ☐

If **NO**, why? ________________________________

Have you seen any other physician or healthcare professional for this complaint? Yes ☐ No ☐

If **YES**, who? ________________________________

Date of last treatment? ________________________________

Were X-rays or any other medical testing performed?

Yes ☐ No ☐

If auto accident, are you claiming under Insurance Corp. of BC (ICBC)?

Yes ☐ No ☐

Date of Accident: ________________________________

ICBC Claim #: ________________________________

Adjustor's Name: ________________________________

Phone #: ________________________________

BC Medical #: ________________________________

HEALTH HISTORY

Please indicate conditions presently causing you problems, as well as conditions which were a problem in the past.

Musculoskeletal System	**Present**	**Past**
Neck Problems	□	□
Jaw Problems	□	□
Upper Back Problems	□	□
Shoulder Problems	□	□
Elbow/Wrist/Knee Problems	□	□
Low Back Problems	□	□
Ankle/Foot Problems	□	□
Arthritis	□	□
Muscle Soreness	□	□
Scoliosis	□	□

Circulatory System	**Present**	**Past**
High Blood Pressure	□	□
High Cholesterol	□	□
Heart Condition	□	□
Aneurysm	□	□
Stroke	□	□
Varicose Veins	□	□
Bleeding Disorder	□	□

Pulmonary	**Present**	**Past**
Asthma	□	□
Chest Pain	□	□
Difficulty Breathing	□	□
Persistent Cough	□	□

Genito-Urinary System	**Present**	**Past**
Painful Urination	□	□
Excessive Urination	□	□
Scanty Urination	□	□
Discolored Urine	□	□

Nervous System	**Present**	**Past**
Headaches	□	□
Numbness/ Loss of feeling	□	□
Dizziness Fainting	□	□
Loss of balance	□	□
Confusion/ Forgetfulness	□	□
Depression	□	□
Fatigue	□	□
Anxiety	□	□

Allergies	**Present**	**Past**
Seasonal/ Hay Fever	□	□
Sinus Pain	□	□
Drug	□	□
Food	□	□

Other:___________________________

Gastrointestinal System	**Present**	**Past**
Poor Appetite	□	□
Excessive Hunger	□	□
Abdominal Pain	□	□
Excessive Thirst	□	□
Nausea/Vomiting	□	□
Diarrhea/ Constipation	□	□
Bloody/Black Stool	□	□
Liver/Gallbladder trouble	□	□
Weight Trouble	□	□
Ulcer	□	□

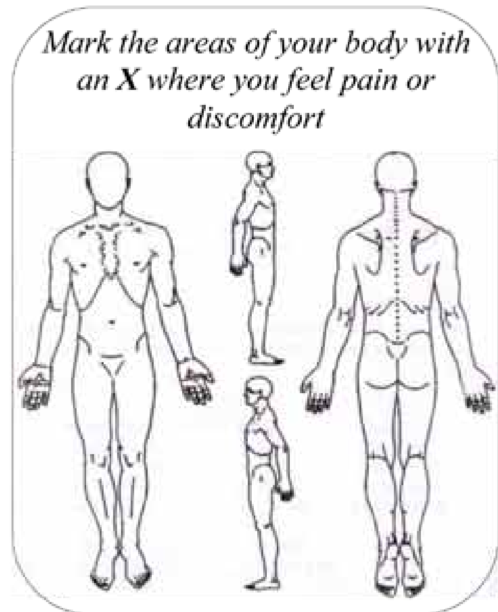
Systemic	**Present**	**Past**
Diabetes	□	□
Hypoglycemia	□	□
Epilepsy	□	□
Rheumatoid	□	□
TB	□	□
HIV/AIDS	□	□
Cancer: Stage: ________	□	□
MS	□	□
Parkinson's	□	□
Thyroid Problems	□	□

Other:______________________________

Ear, Eyes, Nose, Throat	**Present**	**Past**
Eye Problems	□	□
Vision Problems	□	□
Ear Discharge/ Ear Pain	□	□
Ear Ringing/ Hearing loss	□	□
Sore Throat/ Hoarseness	□	□
Enlarge Glands	□	□

Female	**Present**	**Past**
Vaginal Discharge	□	□
Vaginal Bleeding	□	□
Hormonal Contraceptives	□	□
Menstrual pain	□	□
Irregular cycle	□	□
Menopausal?	Yes	No
Pregnant?	Yes	No
Due Date? _____________		

Male	**Present**	**Past**
Prostate Problems	□	□



Orthopedic metal implants?
Yes □ No □
Explain:___________________________

Recent cortisone injections?
Yes □ No □
Explain:___________________________

Had any broken bones?
Yes □ No □
Explain:___________________________

Been struck unconscious?
Yes □ No □
Explain:___________________________

Any significant accidents or injuries?
Yes □ No □
Explain:___________________________

Had surgery?
Yes □ No □
Explain:___________________________

Had any major strains or sprains?
Yes □ No □
Explain:___________________________

Use orthotics, heel lifts, or insoles?
Yes □ No □
Explain:___________________________

Scale from 1 (not painful) to 10 (very painful); please indicate your pain level?

____

The information on this form is true to the best of my memory and I consent to further evaluation as deemed appropriate by the Practitioner.

24 HOUR CANCELLATION FEE WILL APPLY IF PATIENT DOES NOT CALL TO CANCEL 24 HOURS PRIOR TO APPOINTMENT.

Patient Initials: __________

Patient Signature: ____ **Date:** __________________