**Confidential Patient Information**

**Name: (Mr./Ms./Mrs./Dr.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City­­­­:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal code:\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E-mail address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Updated via e-mail Y/N?**

**Date of birth (dd/mm/yyyy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Age\_\_\_\_ Male/Female**

**Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Whom may we thank for referring you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Family Physician’s Name and Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**May we communicate with your MD concerning your health ? Yes/No**

List your chief complaints in order of priority

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

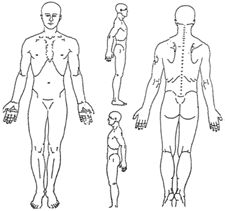
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For how long?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been treated for these conditions before? Y/N

Have you had any diagnostic testing completed (ie. Ultrasound, MRI, CT scan, X-ray)

If so, type\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_ Results:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this a result of an auto or work injury? Auto/Work/None Date of injury?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Please Circle Area of Pain/Discomfort

Please Rate the intensity of your pain (please circle)

0 1 2 3 4 5 6 7 8 9 10

Is it getting: better/worse/same/ comes and goes/ recovering/reoccurring/constant?

**Therapy Goals:** \_\_\_Pain relief \_\_\_ Prevention

\_\_\_Core strength\_\_\_ Improve posture \_\_\_ Stress reduction \_\_\_ Increase Spinal health

Medications you currently take:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgeries in the past:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any other conditions that you have been treated for in the last 10 years:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been to a chiro/physio before? Yes/No if yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had acupuncture before? Yes/No

Are you happy at your current weight? Yes/No

Do you have extended health insurance? Yes/No Name of company?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please indicate the health conditions that apply to you, both past and present;**

* Cancer
* Stroke/Aneurysm
* Spinal Cord Injury
* Low back pain
* Sciatica
* Scoliosis
* Headache/Migraine
* Neck pain
* Joint pain/stiffness
* Arthritis
* Osteoporosis
* Bone Fracture
* Poor circulation/bruising
* Bleeding disorders
* Seizures
* Pain between shoulders
* Numbness/tingling
* Diabetes
* Chronic pain
* Abdominal pain
* Heart disease
* Hypertension
* High Cholesterol
* Chest pain
* Short breath
* Irregular heartbeat
* Blood pressure problems
* Respiratory Problems
* Allergies
* Stress
* Digestive problems
* Bladder problems
* Loss of bowel control
* Loss of bladder control
* Weight trouble
* Kidney problems
* Liver/Gall bladder problems
* Loss of sleep
* Vision problems
* Unconsciousness
* A serious car accident
* HIV/Aids

**List any family members who suffer from the following:**

|  |  |  |  |
| --- | --- | --- | --- |
| Cancer: | Diabetes: | Heart Disease: | Stroke: |
| High Blood pressure: | Arthritis: | Bleeding Disorders: | Seizures: |
| Other: | | | |

**Lower Limb Biomechanics/Circulation**

\_\_\_Flat foot/low arch \_\_\_ Leg/foot Swelling \_\_\_ Spider Veins \_\_\_ High arch

\_\_\_Bunions \_\_\_ Leg foot pain/tiredness \_\_\_ Diabetic \_\_\_Hammer toes

\_\_\_Hip/Knee Pain \_\_\_ Varicose Veins \_\_\_ Overweight \_\_\_Arthritis

\_\_\_Sit/Stand for prolonged periods of time during day

\_\_\_Prescribed compression stockings/socks in the past

**Have you ever worn**;

Orthotics: Yes/No If yes, date dispensed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bracing: Yes/No If yes, type:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Compression Hosiery: Yes/No

**Females only**:

Is there any possibility you are pregnant Yes/No

Menstrual problems? Yes/No Number of Children?\_\_\_\_

|  |  |
| --- | --- |
| **Car Accidents** | **WSIB** |
| Insurance company: | Claim number: |
| Claim number: | Date of accident: |
| Adjustor’s name and phone #: | Employers name and Phone #: |
| Date of accident: | Job Title: |