

## NEW PATIENT FORM

### PATIENT INFORMATION

Mr.  Mrs.  Ms.  Miss  Dr.: \_\_\_\_\_ (Surname) \_\_\_\_\_ (Given Name) \_\_\_\_\_ (MI)

Date of Birth: \_\_\_/\_\_\_/\_\_\_ (dd/mm/yyyy) Age: \_\_\_\_\_ Sex:  M  F

Marital Status:  Single  Married  Divorced  Widowed Spouse Name: \_\_\_\_\_

Names/Ages of Children: \_\_\_\_\_

Address: \_\_\_\_\_ APT: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone #: ( ) \_\_\_\_\_ ( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
home phone # work phone # cell phone #

Leave Messages:  Y  N Email Address: \_\_\_\_\_

Do You Wish To Be Added To Our Electronic Newsletter?:  Y  N

Occupation: \_\_\_\_\_ Employers Name: \_\_\_\_\_

Were You Referred:  Y  N If yes, name of person referring: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Emergency Contact Phone Number: ( ) \_\_\_\_\_

### HEALTH INFORMATION

**Previous Medical Experience**

Previous Chiropractor Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Medical Doctor Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Do you give authorization for the exchange of information with your medical doctor**  Y  N

Have you received physiotherapy treatment before:  Y  N

Have you received acupuncture treatment before:  Y  N Name \_\_\_\_\_

Have you received massage therapy treatment before:  Y  N Therapist Name \_\_\_\_\_

Do you have any extended health coverage:  Y  N Insurer: \_\_\_\_\_

### ABOUT YOUR VISIT

Please specify the reason for today's visit: \_\_\_\_\_

How long has this condition been bothering you?: \_\_\_\_\_

Have you had this pain before?:  Y  N If Yes, When: \_\_\_\_\_

Are the symptoms you are experiencing:  Getting Worse  Remain the same  Getting better

What types of treatment have you received for this condition?: \_\_\_\_\_

Have you ever had any:  X-ray  CT scan  MRI If so, when: \_\_\_\_\_

Are the injuries the result of a workplace accident  Y  N  
(If No, you do not need to fill out the following information)  
Date of accident: \_\_\_/\_\_\_/\_\_\_ (dd/mm/yyyy) WSIB Claim Number: \_\_\_\_\_  
Employer name and telephone number: \_\_\_\_\_

Are the injuries the result of a motor vehicle accident  Y  N  
(If No, you do not need to fill out the following information)  
Date of accident: \_\_\_/\_\_\_/\_\_\_ (dd/mm/yyyy) Policy Claim Number: \_\_\_\_\_  
Insurer name and telephone number: \_\_\_\_\_

Broken bones or Surgeries: \_\_\_\_\_ When? \_\_\_\_\_

Do you have any other conditions that should be brought to the Doctor's attention:  
\_\_\_\_\_

**MEDICATIONS AND SUPPLEMENTS:**

Current Medication and Supplement List: (Please include name and dosage)

Medication 1: _____	Supplement 1: _____
Medication 2: _____	Supplement 2: _____
Medication 3: _____	Supplement 3: _____
Medication 4: _____	Supplement 4: _____
Medication 5: _____	Supplement 5: _____
Medication 6: _____	Supplement 6: _____
Medication 7: _____	Supplement 7: _____

**FAMILY HEALTH HISTORY:**

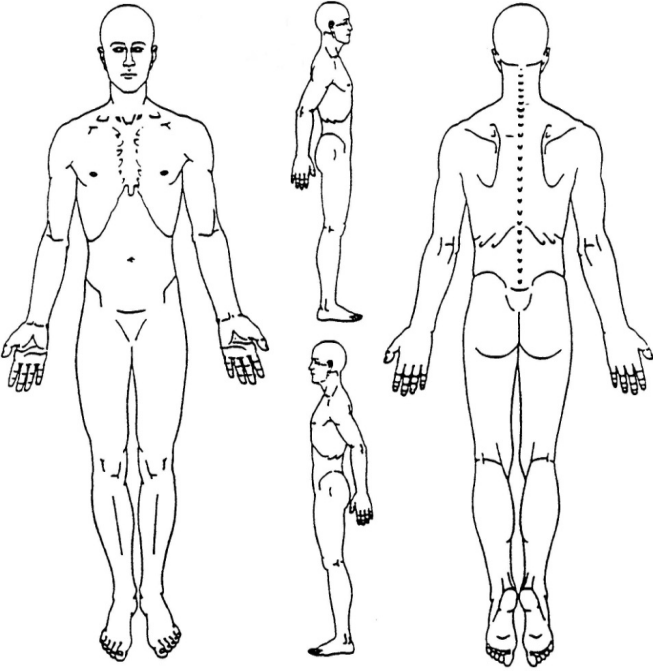



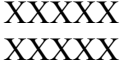


Please check if you or anyone in your family have any of the following:

<input type="checkbox"/> Osteoarthritis	___ Myself ___ Mother ___ Father ___ Sibling ___ Other (specify) _____
<input type="checkbox"/> Osteoporosis	___ Myself ___ Mother ___ Father ___ Sibling ___ Other (specify) _____
<input type="checkbox"/> Cancer	___ Myself ___ Mother ___ Father ___ Sibling ___ Other (specify) _____
<input type="checkbox"/> Heart Disease	___ Myself ___ Mother ___ Father ___ Sibling ___ Other (specify) _____
<input type="checkbox"/> Stroke	___ Myself ___ Mother ___ Father ___ Sibling ___ Other (specify) _____
<input type="checkbox"/> Diabetes	___ Myself ___ Mother ___ Father ___ Sibling ___ Other (specify) _____
<input type="checkbox"/> High Cholesterol	___ Myself ___ Mother ___ Father ___ Sibling ___ Other (specify) _____
<input type="checkbox"/> Hypertension	___ Myself ___ Mother ___ Father ___ Sibling ___ Other (specify) _____
Other conditions: _____	

**SOCIAL HISTORY**

Do you smoke?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, how many packs/day: _____ For how long? _____
Do you consume alcohol?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, how many drinks/week: _____
Do you exercise?	<input type="checkbox"/> Y <input type="checkbox"/> N	If yes, how many times/week? _____

**SYMPTOM DIAGRAM**

Please mark the areas on your body which represent the pain(s) or sensation (s) you are experiencing. Please include <i>all</i> areas. Use symbols provided below.		
Numbness		
Pins & Needles		
Dull & Aching		
Burning		
Sharp & Stabbing		
Stiff and Tight		

**Numeric Pain Rating Scale**

On the scale below, please indicate the intensity of the pain at its **LOWEST** and **HIGHEST** level:

**No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Ever**

**Health Status Survey:** Please circle below any condition you have had or presently have:

<p><b>NEUROLOGICAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Allergy</li> <li><input type="checkbox"/> Chills</li> <li><input type="checkbox"/> Convulsions</li> <li><input type="checkbox"/> Dizziness</li> <li><input type="checkbox"/> Fainting</li> <li><input type="checkbox"/> Fevers</li> <li><input type="checkbox"/> Headache</li> <li><input type="checkbox"/> Loss of sleep</li> <li><input type="checkbox"/> Nervousness</li> <li><input type="checkbox"/> Depression</li> <li><input type="checkbox"/> Neuralgia</li> <li><input type="checkbox"/> Numbness</li> <li><input type="checkbox"/> Sweats</li> <li><input type="checkbox"/> Loss of weight</li> <li><input type="checkbox"/> Tremors</li> <li><input type="checkbox"/> Spinal tap/injections</li> </ul> <p><b>MUSCLE &amp; JOINT</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Arthritis</li> <li><input type="checkbox"/> Bursitis</li> <li><input type="checkbox"/> Foot trouble</li> <li><input type="checkbox"/> Hernia</li> <li><input type="checkbox"/> Low back pain</li> <li><input type="checkbox"/> Neck pain</li> <li><input type="checkbox"/> Neck stiffness</li> <li><input type="checkbox"/> Pain b/w the shoulders</li> <li><input type="checkbox"/> Polio</li> </ul> <p>Do you wear orthotics?</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Yes</li> <li><input type="checkbox"/> No</li> </ul> <p>If yes, how old are they: _____ years Who prescribed them: _____</p> <p><b>RESPIRATORY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Smoking</li> <li><input type="checkbox"/> Chest pain</li> <li><input type="checkbox"/> Chronic cough</li> <li><input type="checkbox"/> Difficulty breathing</li> <li><input type="checkbox"/> Spitting blood</li> <li><input type="checkbox"/> Throat phlegm</li> <li><input type="checkbox"/> Wheezing</li> </ul>	<p><b>EYES, EARS, NOSE &amp; THROAT</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Allergies</li> <li><input type="checkbox"/> Colds</li> <li><input type="checkbox"/> Crossed eyes</li> <li><input type="checkbox"/> Deafness</li> <li><input type="checkbox"/> Dental decay</li> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Earaches</li> <li><input type="checkbox"/> Ear discharge</li> <li><input type="checkbox"/> Ear noises</li> <li><input type="checkbox"/> Sinus infections</li> <li><input type="checkbox"/> Enlarged glands</li> <li><input type="checkbox"/> Enlarged thyroid</li> <li><input type="checkbox"/> Sore throat</li> <li><input type="checkbox"/> Tonsillitis</li> <li><input type="checkbox"/> Eye pain</li> <li><input type="checkbox"/> Failing vision</li> <li><input type="checkbox"/> Farsighted</li> <li><input type="checkbox"/> Gum trouble</li> <li><input type="checkbox"/> Hay fever</li> <li><input type="checkbox"/> Hoarseness</li> <li><input type="checkbox"/> Nasal obstruction</li> <li><input type="checkbox"/> Near sighted</li> <li><input type="checkbox"/> Nosebleeds</li> </ul> <p><b>CARDIOVASCULAR</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Anemia</li> <li><input type="checkbox"/> Rapid heart beats</li> <li><input type="checkbox"/> Slow heart beats</li> <li><input type="checkbox"/> Swelling of the ankles</li> <li><input type="checkbox"/> Hardening of the arteries</li> <li><input type="checkbox"/> High blood pressure</li> <li><input type="checkbox"/> Low blood pressure</li> <li><input type="checkbox"/> Pain over heart</li> <li><input type="checkbox"/> Poor circulation</li> </ul> <p><b>GASTROINTESTINAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Excessive hunger</li> <li><input type="checkbox"/> Burping or gas</li> <li><input type="checkbox"/> Liver trouble</li> <li><input type="checkbox"/> Colitis</li> <li><input type="checkbox"/> Colon trouble</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Difficult digestion</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Distension of abdomen</li> <li><input type="checkbox"/> Stomach pain</li> <li><input type="checkbox"/> Gall bladder trouble</li> <li><input type="checkbox"/> Hemorrhoids</li> <li><input type="checkbox"/> Intestinal worms</li> <li><input type="checkbox"/> Jaundice</li> <li><input type="checkbox"/> Poor appetite</li> <li><input type="checkbox"/> Nausea</li> <li><input type="checkbox"/> Vomiting</li> <li><input type="checkbox"/> Vomit blood</li> </ul> <p><b>SKIN</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Boils</li> <li><input type="checkbox"/> Bruise easily</li> <li><input type="checkbox"/> Dryness</li> <li><input type="checkbox"/> Hives or allergy</li> <li><input type="checkbox"/> Itching</li> <li><input type="checkbox"/> Skin rash</li> <li><input type="checkbox"/> Varicose veins</li> </ul> <p><b>GENITO-URINARY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Bed wetting</li> <li><input type="checkbox"/> Blood in urine</li> <li><input type="checkbox"/> Frequent urination</li> <li><input type="checkbox"/> Incontinence</li> <li><input type="checkbox"/> Kidney infection</li> <li><input type="checkbox"/> Painful urination</li> <li><input type="checkbox"/> Prostate trouble</li> <li><input type="checkbox"/> Pus in urine</li> <li><input type="checkbox"/> Smell of urine</li> </ul> <p><b>PAIN OR NUMBNESS</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Shoulders</li> <li><input type="checkbox"/> Arms</li> <li><input type="checkbox"/> Hands</li> <li><input type="checkbox"/> Hips</li> <li><input type="checkbox"/> Legs</li> <li><input type="checkbox"/> Knees</li> <li><input type="checkbox"/> Ankles</li> <li><input type="checkbox"/> Feet</li> <li><input type="checkbox"/> Painful tail bone</li> <li><input type="checkbox"/> Sciatica</li> <li><input type="checkbox"/> Swollen joints</li> </ul>	<p><b>HAVE YOU HAD ANY OF THE FOLLOWING DISEASES:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Measles</li> <li><input type="checkbox"/> Mumps</li> <li><input type="checkbox"/> Cancer</li> <li><input type="checkbox"/> Goitre</li> <li><input type="checkbox"/> Flu</li> <li><input type="checkbox"/> Chorea</li> <li><input type="checkbox"/> Sciatica</li> <li><input type="checkbox"/> Epilepsy</li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Gout</li> <li><input type="checkbox"/> Pleurisy</li> <li><input type="checkbox"/> Rheumatism</li> <li><input type="checkbox"/> Heart disease</li> <li><input type="checkbox"/> Mental disorders</li> <li><input type="checkbox"/> Venereal infection</li> <li><input type="checkbox"/> HIV/AIDS</li> <li><input type="checkbox"/> Hepatitis</li> </ul> <p><b>SURGICAL HISTORY:</b></p> <hr/> <hr/> <hr/> <hr/> <p>Have you been treated by a physician for any health condition in the last year? YES/NO Describe condition: _____</p> <hr/> <p>Date of last physical exam: _____</p> <p><b>FOR WOMEN ONLY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cramps</li> <li><input type="checkbox"/> Heavy flow</li> <li><input type="checkbox"/> Light flow</li> <li><input type="checkbox"/> Irregular cycle</li> <li><input type="checkbox"/> Painful cycle</li> <li><input type="checkbox"/> Discharge</li> <li><input type="checkbox"/> Sore breasts</li> </ul> <p>Number of children: _____</p> <p>Menopausal: YES NO Last menstruation date: _____</p> <p>Pregnant: YES NO Due date: _____</p>
---	---	--	--

**CONSENT FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION:**

Please note that all healthcare providers subcontracted by Absolute Endurance Training & Therapy will have access to your patient files, which will be kept confidential amongst them unless otherwise agreed upon in writing by the patient.

All personal information collected, including medical information, will remain safe and secured and will NOT be shared with any other healthcare providers who are NOT subcontracted by Absolute Endurance Training & Therapy unless otherwise agreed upon by in writing by the patient.

Information may be collected via phone, personal interview, direct examination, transfer of medical information from other health care professionals, and third parties including insurance companies.

Personal health information will only be seen by the healthcare professionals at Absolute Endurance Training & Therapy. In an event where personal information is required by insurance companies, regulatory bodies, and health care professionals, verbal consent will be obtained before information is transferred.

For further information on the Personal Information Protection Electronic Document Act visit:  
[www.privcom.gc.ca](http://www.privcom.gc.ca)

By signing this form, I hereby consent to the collection, use, and disclosure of my personal information.

Patient or Guardian name: \_\_\_\_\_ Signature of patient or guardian: \_\_\_\_\_

Signature of Healthcare Provider: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy)

### **CONSENT TO EXAMINATION**

All healthcare providers including Doctors of Chiropractic and Physiotherapists who conduct physical examinations are required to advise patients that there are some risks associated with such examination.

I understand and am informed that as in all healthcare, a physical examination is meant to provide the healthcare professional with the opportunity to obtain useful information about individuals. The examination also allows the healthcare professional to establish relationships and to detect and address problems in their earliest stages for beneficial results.

I further understand that there are some very slight risks to the examination including but not limited to an aggravation of symptoms or the need for further diagnostic testing.

I understand that I will have the opportunity to discuss the details of the examination with the healthcare providers at Absolute Endurance Training & Therapy and I understand that I am able to discuss the nature and purpose of the examination at any time as well as the contents of this consent.

I hereby consent to the examination offered or recommended to me Absolute Endurance Training & Therapy.

Patient/Guardian Name: \_\_\_\_\_ Signature of patient/Guardian: \_\_\_\_\_

Healthcare provider: \_\_\_\_\_ Date Signed: \_\_\_/\_\_\_/\_\_\_ (mm/dd/yyyy)