

Patient Information

1/10

Date: DD/MM/YYYY **Full Name:** **Preferred Name:**
Sex: Male Female **Birthdate:** DD/MM/YYYY **Age:** **Marital Status:**
Alberta Health Care #: **Street Address:**
Cell#: **Postal Code:** **City:** **Prov:**
Home #: **Email:**
Occupation: **Employer:**
Emergency Contact: **Relationship:** **Phone #:**
** We communicate appointment reminders, invoices, receipts, exercise programs & health tips via email. We hate spam, but we really value educational information. Do we have permission to utilize your email address ? Yes No*

Medical Information

2/10

Family Medical Doctor's Name: **Clinic:**
Date of last MD visit: **Reason:**
Date of last physical examination:
What therapies have you previously received? Chiropractic Massage Acupuncture Physiotherapy
** Communication between healthcare providers can greatly improve the quality and safety of patient care. If necessary, do you consent to allow your health provider at PHP to contact your medical doctor? Yes No*

Extended Health Benefits & Other Insurance

3/10

Do you have a private insurance plan? No Yes (Self) Yes (Spouse) Yes (Parent)
Name of primary policy holder (Spouse/Parent):
Policy #: **Which Company?** Alberta Blue Cross (ABC) SunLife
Member ID: **Group #:** (ABC Only) Great West Life Green Shield Standard Life
Is this a Workman's Compensation Case (WCB)? No Yes SSQ Financial Chamber of Commerce Desjardins
Date of Accident: Cowan Industrial Alliance Johnson
Is this a Motor Vehicle Accident Case (MVA)? No Yes Manulife Other:
Date of Accident:

How Did You Hear About Us?

4/10

Referred by Friend/Family Referred by Medical Doctor Internet/Website Street Sign
 Referred by Trainer Walk In Health Care Event Other:

**Whom may we thank for this referral?*

Current Health Condition &/Or Injury

5/10

Primary Complaint:

When did this begin?

Have you had this before? No Yes; When:

Is it getting: Worse Better Not Changing

What is the character of the pain? Dull & Achy Numb Stiff & Tight Pins & Needles Sharp Burning

Is the Condition: Work-Related Auto-Related Fall Sports-Related Other:

Please rate your pain: (LEAST) 0 1 2 3 4 5 6 7 8 9 10 (WORST)

When do you feel the pain? Constantly Intermittently Only at Night Only in the Morning

Does the pain radiate down your legs or arms? No Yes; Describe:

Have you seen anyone else for this condition? No Yes; Who:

Have you had any imaging for this condition: X-Ray CT MRI Ultrasound Date:

What aggravates your pain? Sitting Standing Rest Bending Lifting Exercise Weather Changes

What relieves your pain? Rest Movement Heat Ice Massage Medication:

Does this problem interfere with: Work Family & Social Life Sports & Hobbies Sleep

What is your commitment to correcting this problem: 0 1 2 3 4 5 6 7 8 9 10

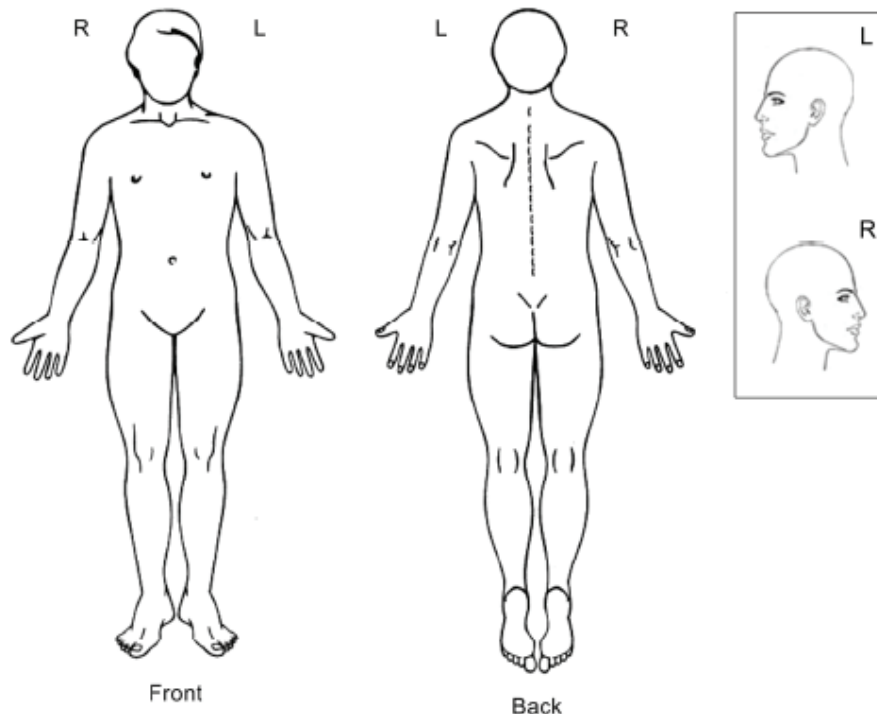
Do you have any secondary complaints?

Symptom Diagram

6/10

Please use the symbols below to mark all of the areas on the diagram that BEST represent the pain and sensations that you are CURRENTLY experiencing:

Numbness	====	Pins/Needles	~~~~	Burning	oooo
Sharp	xxxx	Dull/Achy	ΔΔΔΔ	Stiff/Tight	2222



Health History

7/10

Have You Ever Had...

- Fracture:** No Yes; where/ when:
- Major Surgery:** No Yes; where/when:
- Car Accident:** No Yes; when:
- A Concussion:** No Yes; when/ how:
- Been Hospitalized:** No Yes; when/why:
- Been Diagnosed With:** Cancer HIV/AIDS Hepatitis A/B/C Other: When:
- Do you have any allergies:** No Yes; List:
- Please list any medications/supplements that you are currently taking:**

Family History

8/10

- | Is there a family history of: | Heart Disease | Stroke | Cancer | Diabetes | Arthritis | Other |
|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------|
| *Mother's Side: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| *Father's Side: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

Lifestyle

9/10

- Are you currently a smoker?** No Yes; amount:
- Did you smoke previously?** No Yes; when:
- Do you exercise regularly?** No Yes; type & frequency:
- Do you consume alcohol?** No Yes; amount/frequency:
- Coffee?** No Yes; amount:
- Do you have a healthy & balanced diet?** No Don't Know Yes, I think so Yes, definitely
- What are your stress levels?** Extreme High Moderate Low Very Minimal

Health Status Survey

10/10

Please check the box of any conditions or symptoms that you have had in the past six months:

- | | | | | | |
|---|---|--|---|---|--|
| General: | Neurological: | Cardiovascular: | Respiratory: | Genitourinary: | |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Angina | <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Infection | |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Menopause | |
| <input type="checkbox"/> Night Pain | <input type="checkbox"/> Nausea | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Painful Breasts | |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Ankle Swelling | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Prostate Trouble | |
| <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Clumsiness | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Sinus Infections | <input type="checkbox"/> Trouble Urinating | |
| <input type="checkbox"/> Loss of Weight | <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Previous Stroke | <input type="checkbox"/> Spitting up Blood | <input type="checkbox"/> Blood in Urine/Stool | |
| <input type="checkbox"/> Anxiety/Nervous | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Spitting up Phlegm | <input type="checkbox"/> Painful Menstruation | |
| <input type="checkbox"/> Excessive Sweating | <input type="checkbox"/> Numbness/Tingling | <input type="checkbox"/> Previous Heart Attack | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Irregular/Absent Cycle | |
| Eyes/Ears/Nose/Throat: | | Muscle & Joint: | | | |
| <input type="checkbox"/> Eye Pain | <input type="checkbox"/> Earaches/Infection | <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Shoulder/Arm Pain | <input type="checkbox"/> TMJ/Jaw Pain | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Hearing Difficulty | <input type="checkbox"/> Mid Back Pain | <input type="checkbox"/> Knee/Leg Pain | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Ankle/Foot Pain |
| <input type="checkbox"/> Worsening Vision | | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Hip/Groin Pain | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout |
| | | <input type="checkbox"/> Elbow Pain | <input type="checkbox"/> Wrist/Hand Pain | <input type="checkbox"/> Disc Herniation | |