

Patient Information 1/7

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 2/7

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 3/7

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? 4/7

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?

Health History

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Primary Complaint: When did this begin?

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

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

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

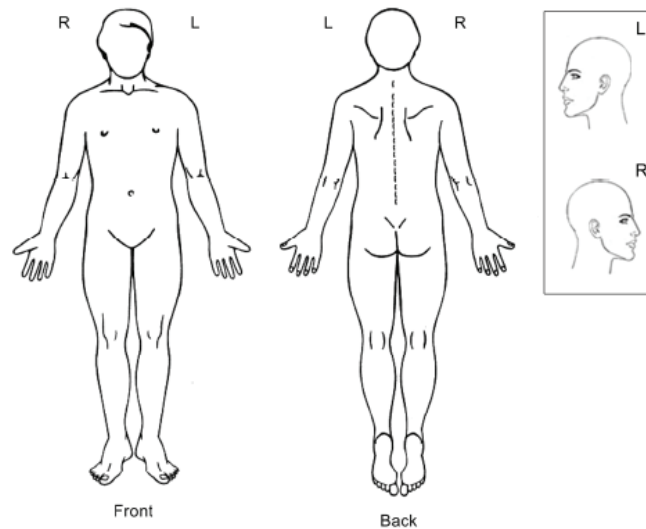
What Type of Massage do you prefer? Deep Tissue Relaxation Pregnancy MLD Other:

Symptom Diagram

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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 Status Survey

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

General:

- Fever
- Fainting
- Night Pain
- Headaches
- Loss of Sleep
- Loss of Weight
- Anxiety/Nervous
- Excessive Sweating

Neurological:

- Dizziness
- Paralysis
- Nausea
- Convulsions
- Clumsiness
- Blurred Vision
- Loss of Balance
- Numbness/Tingling

Cardiovascular:

- Angina
- Chest Pain
- Varicose Veins
- Ankle Swelling
- Poor Circulation
- Previous Stroke
- Irregular Heartbeat
- Previous Heart Attack

Respiratory:

- Asthma
- Sore Throat
- Frequent Colds
- Chronic Cough
- Sinus Infections
- Spitting up Blood
- Spitting up Phlegm
- Difficulty Breathing

Genitourinary:

- Kidney Infection
- Menopause
- Painful Breasts
- Prostate Trouble
- Trouble Urinating
- Blood in Urine/Stool
- Painful Menstruation
- Irregular/Absent Cycle

Eyes/Ears/Nose/Throat:

- Eye Pain
- Ringing in Ears
- Worsening Vision
- Earaches/Infection
- Hearing Difficulty

Muscle & Joint:

- Low Back Pain
- Mid Back Pain
- Neck Pain
- Elbow Pain
- Shoulder/Arm Pain
- Knee/Leg Pain
- Hip/Groin Pain
- Wrist/Hand Pain
- TMJ/Jaw Pain
- Fibromyalgia
- Arthritis
- Disc Herniation
- Sciatica
- Ankle/Foot Pain
- Gout