shift CONCUSSION MANAGEMENT PROGRAM
CERTIFIED PROVIDER

PATIENT ENTRANCE FORM

PETERBOROUGH WELLNESS GROUP

Name: _____ Date: _____
(Title) (First) (Middle Initial) (Last)

Address: _____ Postal Code: _____

Phone (H): _____ Phone (C): _____ Phone (Work): _____

Email: _____ Date of Birth: _____ M ❑ F ❑ Age: _____

Marital Status: _____ Children: _____

Occupation (Your): _____ Employer: _____

Employer Phone: _____ Address: _____

Extended Health Care Company: _____ Policy# _____

Emergency Contact: _____ Relation: _____ Phone: _____

How did you hear about our Office? _____

CLAIM WILL BE MADE AGAINST:

1. Recent Motor Vehicle Accident Yes ❑ No ❑ (if Yes, see attached)
2. Work Related Injury/Accident (WSIB claim) Yes ❑ No ❑ (if Yes, see attached)

PRIOR CHIROPRACTIC CARE:

Have you ever been to a Chiropractor before? Yes ❑ No ❑

Chiropractor Name: _____ Clinic: _____

Date of Last Visit: _____ X-rays taken: Yes ❑ No ❑ What areas of Body? _____

Were you satisfied with your care? _____ Reason for Visit: _____

MEDICAL DOCTOR:

Name: _____ Phone: _____

Date of Last Appointment: _____ Date of Last Physical: _____

Reason for Visit: _____

_____

291 Charlotte St. Peterborough, On K9J2V6
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Description of current injury/pain: Primary reason for coming to clinic (detailed description)

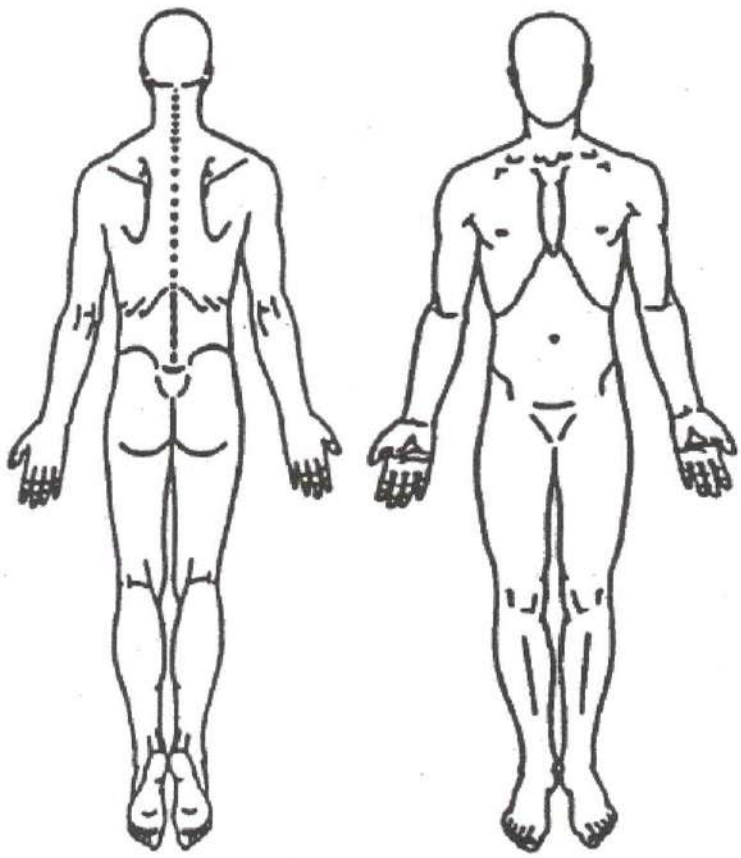
_____

_____

_____

_____

_____



Characteristics of the pain/complaint
Using the key below, please mark the areas of your body where you feel the described sensations. Use the appropriate symbols to show areas of pain or unusual feeling.

XXX = Sharp Pain/Stabbing

TTT = Tense/Tight

BBB = Burning

AAA = Aching/Dull

+++ = Pins & Needles

///// = Numbness

OOO = Other (describe)

Please circle the appropriate intensity of your pain from 0-10 below:
No Pain 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 Severe Pain

Is this due to an accident? Yes❑ No❑ Auto❑ Work❑ Home❑ Sports❑ Other❑ Date: _____

What treatments have you had for this problem? _____
Chiropractic❑ Physical Therapy❑ Massage❑ Medical Treatment❑ Acupuncture❑ Other❑
Have you had any diagnostic studies: X-ray❑ MRI❑ CT scan❑ Lab Work❑ Other: _____

Are you currently under a doctor's care for this condition or any other condition? Yes❑ No❑
What condition(s)? _____
What Doctor(s)? _____

Have you ever had any of the following: aneurysm❑ arthritis❑ epilepsy❑
heart conditions❑ pneumonia❑ polio❑ cancer❑ strokes❑

_____

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PATIENT PAST HISTORY

Illnesses: Have you had any significant illnesses as an : Infant ❑ Child ❑ Teen ❑ Adult ❑
Yes ❑ No ❑ (list)_____

_____

Do you currently have an illness? _____

Medications: List any drugs or medications you are currently taking.

_____

_____

Injuries: Have you ever had any significant injuries. (Detailed description and date).

_____

_____

Falls or Accidents – List: _____

_____

Surgeries and Operations – List: _____

_____

Fractures or Dislocations – List: _____

_____

Have you ever lost consciousness, or experienced a concussion: Yes ❑ No ❑ _____
Have you ever been hospitalized: Yes ❑ No ❑ _____

Any family health conditions or problems Yes ❑ No ❑
Please list: _____

Habits of Lifestyle:
Do you smoke: Yes ❑ No ❑ Do you have more than 2 alcoholic drinks a day Yes ❑ No ❑
Do you exercise: Yes ❑ No ❑ How many times a week: _____
In what sports or recreational activities: _____

How many hours a night do you sleep: 4-6 6-8 8-10 Do you get enough restful sleep Yes ❑ No ❑

Rate your appetite:	Poor	Fair	Medium	Good	Excellent
Rate your diet:	Poor	Fair	Medium	Good	Excellent
How many meals a day:	1 meal	2 meals	3 meals	4 meals	> 4 meals

How would you rate your current level of stress: low ❑ moderate ❑ high ❑ extreme ❑

Do you suffer from any other health conditions? _____

_____

Name: _____ Date: _____

_____

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Peterborough Wellness Group

Please check the appropriate box for any of the following symptoms which you now have or have previously had. C-Currently P=Previously

C	P	
❑	❑	Diabetes
❑	❑	Blackouts/fainting
❑	❑	Convulsions
❑	❑	Chills
❑	❑	Nervousness
❑	❑	Dizziness
❑	❑	Loss of sleep
❑	❑	Fever
❑	❑	Sweats
❑	❑	Tremors
❑	❑	Loss of balance/coordination
❑	❑	Numbness in hand/arm
❑	❑	Numbness in leg/foot
❑	❑	Facial numbness
❑	❑	Numbness other regions
❑	❑	Depression
❑	❑	Fatigue
❑	❑	Anxiety
❑	❑	Allergies
❑	❑	Recent weight gain
❑	❑	Recent weight loss

C	P	**Gastrointestinal**
❑	❑	Poor appetite
❑	❑	Loss of weight
❑	❑	Indigestion
❑	❑	Nausea
❑	❑	Vomitting
❑	❑	Vomit blood
❑	❑	Diarrhea
❑	❑	Constipation
❑	❑	Jaundice
❑	❑	Stomach pain
❑	❑	Liver trouble
❑	❑	Gall bladder trouble
❑	❑	Colon trouble
❑	❑	Excessive hunger
❑	❑	Ulcer
❑	❑	Hemorrhoids
❑	❑	Unusual bowel patterns

C	P	**Muscle/Joint**
❑	❑	Osteoporosis
❑	❑	Headaches
		❑ hormonal
		❑ migraines
		❑ tension/stress/posture
		❑ cervicogenic
		❑ weather related
		❑ other
❑	❑	Bursitis
❑	❑	Foot trouble
❑	❑	Swollen joints
❑	❑	Hernia
❑	❑	Low back pain
❑	❑	Mid back pain
❑	❑	Neck pain
❑	❑	Neck stiffness
❑	❑	Joint pain
❑	❑	Childhood growing pains
❑	❑	Weakness

C	P	**Respiratory**
❑	❑	Asthma
❑	❑	Chest pain
❑	❑	Chronic cough
❑	❑	Difficulty breathing
❑	❑	Wheezing
❑	❑	Spitting blood

C	P	**Cardiovascular**
❑	❑	Rapid heart beats
❑	❑	Slow heart beats
❑	❑	Swelling of ankles
❑	❑	High blood pressure
❑	❑	Low blood pressure
❑	❑	Pain over heart
❑	❑	Poor circulation

C	P	**Skin**
❑	❑	Itching
❑	❑	Sking rashes
❑	❑	Varicose veins
❑	❑	Lumps
❑	❑	Bruises easily
❑	❑	Abnormal hair growth/loss

C	P	**EENT**
❑	❑	Earache
❑	❑	Hearing loss
❑	❑	Loss of balance
❑	❑	Ringing in ear
❑	❑	Ear discharge
❑	❑	Eye pain
❑	❑	Blurred/double vision
❑	❑	Wear glasses/contacts
❑	❑	Visusl problems
❑	❑	Loss of smell
❑	❑	Sinus infections
❑	❑	Nose bleeds
❑	❑	Enlarged glands
❑	❑	Enlarged thyroid
❑	❑	Sore throat
❑	❑	Tonsillitis
❑	❑	Difficulty swallowing

C	P	**Genito-Urinary**
❑	❑	Painful urination
❑	❑	Difficulty urinating
❑	❑	Changes in frequency/colour
❑	❑	Blood in urine
❑	❑	Prostate problems
❑	❑	Venereal disease/discharge
❑	❑	Kidney trouble/infection
❑	❑	Bedwetting

C	P	**Women Only**
❑	❑	Menstrual irregularities
❑	❑	Menstrual pain/cramps
❑	❑	Breast soreness

Pregnant Yes ❑ No ❑

Due Date: _____

Menopausal Yes ❑ No ❑

Last menstrual date: _____

C	P	**Other**
❑	❑	Mental health conditions
❑	❑	HIV/AIDS/Hepatitis
❑	❑	Diseases/illnesses

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Please check the phrase that most represents your reasons for care!

- ❑ **Symptom Relief**: i.e. Get rid of the pain!
- ❑ **Corrective/Functional Care**: i.e. Get rid of the pain, but also address any underlying factors that may contribute to my symptoms, or may cause future problems, ex. Weak muscles, chronic spinal dysfunction, poor posture, chronic tightness. etc.
- ❑ **Performance/Wellness Care**: i.e. I acknowledge that there are many causes of daily repeated physical stress to my body – keep me performing my best – at home, at work, at sport, and or at play.

What are your expectations – What would you like to achieve by coming to our clinic?
Our primary goal is to always work towards the resolution of your condition, as quickly as possible. Help us achieve your goal by listing your expectations!

_____

_____

_____

Before we begin treatment, do you have any questions or concerns that you would like us to address about the therapy? This can include chiropractic manipulation, previous experiences, office policies, health questions? We believe that good patient communication is essential and we always want to understand your perspective – both positive and negative!

_____

_____

_____

_____

Is there a particular technique you would prefer us to use in the treatment of your case?
Our clinician will use the most appropriate techniques for the resolution of your health!

- ❑ **I would like the doctor to decide which technique is the most appropriate for my condition**
- ❑ Chiropractic manipulation/mobilization
- ❑ Myofascial Release Technique (MRT)
- ❑ Personal Training
- ❑ Acupuncture (Electro and Manual)
- ❑ Exercise and Rehabilitation protocols: Shoulder, Knee, Back, Neck, Whole Body (please circle)
- ❑ Core Strengthening; Stretching protocols
- ❑ Laser, Ultrasound, Electrical Therapies
- ❑ Kinesiotape

Financial Policy:

Payment is due at the time services are rendered. Patients are responsible for their accounts. **Our office does not file insurance claims for you**; however we will provide you with a receipt for you to submit for reimbursement. We do require 24 hours notice for cancelled appointments. Missed appointments will be charged $5.00, Subsequent missed appointments will be charged 50% of the regular fee to the patients account. I have read and understand Peterborough Chiropractic Group's financial policy and hereby agree to pay any and all charges at the time services are rendered.

Signature: _____ Date: _____

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CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

PETERBOROUGH WELLNESS GROUP

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CONSENT TO CHIROPRACTIC TREATMENT

It is important to consider the benefits, risks and alternatives to treatment. This will help you make an informed decision about proceeding with care.

Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body. It also includes soft-tissue techniques, therapeutic modalities and exercise.

Benefits - Chiropractic treatment has been shown to be effective for complaints of the neck, back and other areas of the body related to nerves, muscles and joints. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility and improve function.

Risks - The risks associated with chiropractic treatment vary according to each patient's condition and the location and type of treatment. The risks include:

- **Temporary discomfort or worsening of symptoms** – Treatment may cause some discomfort or an increase in pre-existing symptoms of pain or stiffness. This can last a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur with the use of some types of electrical and light therapies. Skin irritation should resolve. A burn may leave a permanent scar.
- **Sprain or strain** – A muscle or ligament sprain or strain may occur. These should resolve within a few days or weeks with rest, minor care and/or protection of the affected area.
- **Rib fracture** – A rib fracture may occur. This can be painful and limit your activity for some time. These usually heal over several weeks with or without further treatment.
- **Disc injury or aggravation** – Some reported cases associate chiropractic treatment with injury or aggravation of a disc condition. This is rare. Spinal discs may degenerate with age or become damaged, with or without symptoms. Signs and symptoms may include neck and back pain, impaired mobility, or radiating pain and numbness into the legs or arms. In severe cases, impaired bowel or bladder function or impaired leg or arm function may occur, which may need surgery.
- **Stroke** – Some reported cases associate chiropractic treatment of the neck with stroke. This is rare. This type of stroke is a serious event involving arteries in the neck and the interruption of blood flow to the brain. The consequences of a stroke can include impairment of vision, speech, balance and brain function, as well as paralysis or death. If signs of stroke occur, seek medical attention immediately.

Alternatives - Alternatives to chiropractic treatment may include consulting other health professionals, over-the-counter pain relievers, rest, and exercise. Each may have their own benefits and risks.

Questions or concerns - Please ask questions at any time about your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time. You are encouraged to be involved in and responsible for your care. Inform your chiropractor immediately of any change in your health or condition.

I acknowledge that I have discussed my condition and the treatment plan with the chiropractor. I understand the nature of the treatment offered to me. I have considered the benefits and risks of treatment and the treatment alternatives. I have read this form or had it read to me. I consent to chiropractic treatment as proposed to me.

Do not sign this form until you meet with the chiropractor.

_____
Patient Name (print)

_____ _____ _____
Patient/Guardian Signature Date Chiropractor Signature