KINESIS HEALTH ASSOCIATES
PATIENT PAST HISTORY FORM

Name:________________________________ Date:___________________________

Please check the appropriate box for any of the following symptoms which you now have or have previously had.

C = Constant F = Frequent O = Occasional

C F O

NEUROLOGICAL

☐ ☐ ☐ Allergy
☐ ☐ ☐ Chills
☐ ☐ ☐ Convulsions
☐ ☐ ☐ Dizziness
☐ ☐ ☐ Fainting
☐ ☐ ☐ Fevers
☐ ☐ ☐ Headaches
☐ ☐ ☐ Loss of Sleep
☐ ☐ ☐ Nervousness
☐ ☐ ☐ Depression
☐ ☐ ☐ Neuralgia
☐ ☐ ☐ Numbness
☐ ☐ ☐ Sweats
☐ ☐ ☐ Loss of Weight
☐ ☐ ☐ Tremors

MUSCLE & JOINT

☐ ☐ ☐ Arthritis
☐ ☐ ☐ Bursitis
☐ ☐ ☐ Foot Trouble
☐ ☐ ☐ Hernia
☐ ☐ ☐ Low Back Pain
☐ ☐ ☐ Neck Pain
☐ ☐ ☐ Neck Stiffness
☐ ☐ ☐ Pain between Shoulders

RESPIRATORY

☐ ☐ ☐ Chest Pain
☐ ☐ ☐ Chronic Cough
☐ ☐ ☐ Difficulty Breathing
☐ ☐ ☐ Spitting Blood
☐ ☐ ☐ Throat Phlegm
☐ ☐ ☐ Wheezing

EYES, EARS, NOSE & THROAT

☐ ☐ ☐ Colds
☐ ☐ ☐ Crossed Eyes
☐ ☐ ☐ Deafness
☐ ☐ ☐ Dental Decay
☐ ☐ ☐ Asthma
☐ ☐ ☐ Ear Aches
☐ ☐ ☐ Ear Discharges

C F O

☐ ☐ ☐ Ear Noises
☐ ☐ ☐ Sinus Infections
☐ ☐ ☐ Enlarged Glands
☐ ☐ ☐ Enlarges Thyroid
☐ ☐ ☐ Sore Throat
☐ ☐ ☐ Tonsillitis
☐ ☐ ☐ Eye Pain
☐ ☐ ☐ Failing Vision
☐ ☐ ☐ Far Sighted
☐ ☐ ☐ Gum trouble
☐ ☐ ☐ Hay Fever
☐ ☐ ☐ Hoarseness
☐ ☐ ☐ Nasal Obstruction
☐ ☐ ☐ Near Sighted
☐ ☐ ☐ Nosebleeds

CARDIO-VASCULAR

☐ ☐ ☐ Rapid Heart beats
☐ ☐ ☐ Slow Heart beat
☐ ☐ ☐ Swelling of Ankles
☐ ☐ ☐ Hardening of Arteries
☐ ☐ ☐ High Blood Pressure
☐ ☐ ☐ Low Blood Pressure
☐ ☐ ☐ Pain over Heart
☐ ☐ ☐ Poor Circulation

GASTRO INTESTINAL

☐ ☐ ☐ Excessive hunger
☐ ☐ ☐ Burping or Gas
☐ ☐ ☐ Liver Trouble
☐ ☐ ☐ Colitis
☐ ☐ ☐ Colon Trouble
☐ ☐ ☐ Constipation
☐ ☐ ☐ Diarrhea
☐ ☐ ☐ Difficult Digestion
☐ ☐ ☐ Distension of Abdomen
☐ ☐ ☐ Stomach Pain
☐ ☐ ☐ Gall Bladder Trouble
☐ ☐ ☐ Hemorrhoids
☐ ☐ ☐ Intestinal Worms
☐ ☐ ☐ Jaundice
☐ ☐ ☐ Poor Appetite
☐ ☐ ☐ Nausea
☐ ☐ ☐ Vomiting
☐ ☐ ☐ Vomit Blood

C F O

SKIN

☐ ☐ ☐ Boils
☐ ☐ ☐ Bruise Easily
☐ ☐ ☐ Dryness
☐ ☐ ☐ Hives or Allergy
☐ ☐ ☐ Itching
☐ ☐ ☐ Skin Rash
☐ ☐ ☐ Varicose Veins

GENITO-URINARY

☐ ☐ ☐ Bedwetting
☐ ☐ ☐ Blood in Urine
☐ ☐ ☐Frequent Urination
☐ ☐ ☐ Loss of Bladder Control
☐ ☐ ☐ Kidney Infection
☐ ☐ ☐ Painful Urination
☐ ☐ ☐ Prostate Trouble
☐ ☐ ☐ Pus in Urine
☐ ☐ ☐ Abnormal smell of urine

PAIN OR NUMBNESS IN:

☐ ☐ ☐ Shoulders
☐ ☐ ☐ Arms
☐ ☐ ☐ Hands
☐ ☐ ☐ Hips
☐ ☐ ☐ Legs
☐ ☐ ☐ Knees
☐ ☐ ☐ Ankles
☐ ☐ ☐ Feet
☐ ☐ ☐ Painful Tail Bone
☐ ☐ ☐ Sciatica
☐ ☐ ☐ Swollen Joints

FOR WOMEN ONLY

☐ ☐ ☐ Cramps
☐ ☐ ☐ Heavy Flow
☐ ☐ ☐ Light Flow
☐ ☐ ☐ Irregular Cycle
☐ ☐ ☐ Painful Cycle
☐ ☐ ☐ Discharge
☐ ☐ ☐ Sore Breasts

Menopausal: ☐ Yes ☐ No
Last Menstruation date: _____________
Pregnant: ☐ Yes ☐ No
Due Date: ___________

Kinesis Health Associates
Symptom Diagram

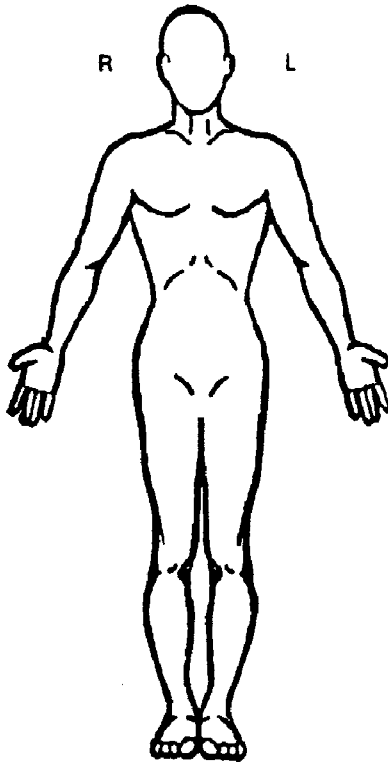
Patient Name: ________________________________ File #: _____________ Date: ____________________

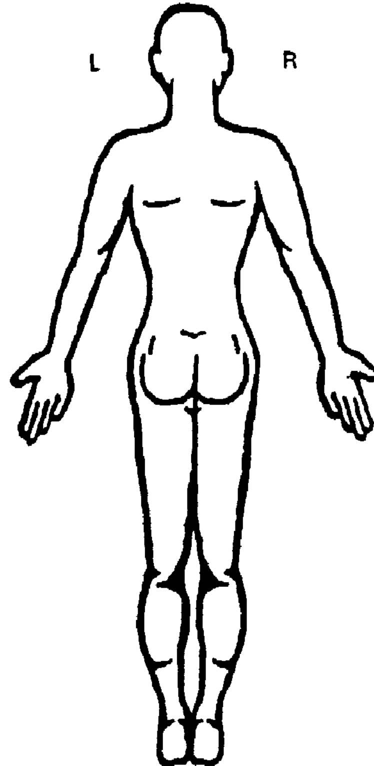
In the diagram provided below, please mark the areas on your body that you feel best represent the pain(s) or sensation(s) you are experiencing. Please include all areas. Use the symbols provided below.

Symbols:

numbness	**= = =** **= = =**	**pins and needles**	***** *****
burning	**X X X** **X X X**	**stabbing &sharp**	*//////////* *//////////*
dull & aching	**+ + + +** **+ + + +**	**stiff and tight**	**2 2 2** **2 2 2**

Front **Back**





Please provide the following information:

SHOE SIZE _______ HEIGHT ________ WEIGHT________

BACK PAIN & DISABILITY QUESTIONNAIRE (Revised Oswestry)

Patient Name: ________________________________ File #:_______________ Date: ______________

PLEASE READ INSTRUCTIONS:

This Questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer each section and mark in only ONE box which applies to you. We realize you may consider that two of the statements in any one section to relate to you, but just mark the box which most closely describes your problem.

Section 1 – PAIN INTENSITY
- ☐ The Pain comes and goes and is very mild.
- ☐ The pain is mild and does not vary much.
- ☐ The pain comes and goes and is moderate
- ☐ The pain is moderate and does not vary much
- ☐ The pain comes and goes and is severe
- ☐ The pain is severe and does not vary much.

Section 2 – PERSONAL CARE
- ☐ I would not have to change my way of washing or dressing in order to avoid pain
- ☐ I do not normally change my way of washing or dressing even though it causes pain.
- ☐ Washing and dressing increase the pain but I manage not to change my way of doing it.
- ☐ Washing and dressing increase the pain and I find it necessary to change my way of doing it
- ☐ Because of the pain, I am unable to do some washing and dressing without help.
- ☐ Because of the pain, I am unable to do any washing and dressing without help.

Section 3 – LIFTING
- ☐ I can lift weights without extra pain
- ☐ I can lift heavy weights but it causes extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor.
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (e.g. on a table)
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights, if they are conveniently positioned.
- ☐ I can only lift very light weights at the most.

Section 4- WALKING
- ☐ I have no pain on walking
- ☐ I have some pain on walking but it does not increase with distance
- ☐ I cannot walk more then one km, without increasing pain
- ☐ I cannot walk more then ½ km, without increasing pain
- ☐ I cannot walk more then ¼ km, without increasing pain
- ☐ I can not walk at all without increasing pain

Section 5- SITTING
- ☐ I can sit in any chair as long as I like
- ☐ I can only sit in my favorite chair as long as I like.
- ☐ Pain prevents me from sitting more then one hour
- ☐ Pain prevents me from sitting for more then 30 minutes
- ☐ Pain prevents me from sitting more then 10 minutes
- ☐ I avoid sitting because it increases pain straight away.

Section 6- STANDING
- ☐ I can stand as long as I want without pain
- ☐ I have some pain on standing but it does not increase with time
- ☐ I can not stand longer then 1 hour without increasing pain
- ☐ I can not stand longer then ½ hour without increasing pain
- ☐ I can not stand longer then 10 minutes without increasing pain
- ☐ I avoid standing because it increases pain straight away.

Section 7- SLEEPING
- ☐ I get no pain in bed
- ☐ I get pain in bed but it does not prevent me from sleeping well.
- ☐ Because of my pain, my normal night's sleep is reduce less then ¼
- ☐ Because of my pain, my normal night's sleep is reduce less then ½
- ☐ Because of my pain, my normal night's sleep is reduce less then ¾
- ☐ Pain prevents me from sleeping at all

Section 8- SOCIAL LIFE
- ☐ My social life is normal and gives me no pain
- ☐ My social life is normal but increases the degree of pain
- ☐ Pain has no significant effect on my social life apart from limiting my more energetic interests(e.g. dancing etc)
- ☐ Pain has restricted my social life and I do not go out very often
- ☐ Pain has restricted my social life to my home
- ☐ I have hardly any social life because of the pain.

Section 9- TRAVELLING
- ☐ I get no pain while travelling
- ☐ I get some pain whilst travelling but none of my usual forms of travel make it worse
- ☐ I get extra pain while travelling but it does not compel me to seek alternative forms of travel.
- ☐ I get extra pain whilst travelling which compels me to seek alternative forms of travel
- ☐ Pain prevents all forms of travel except that of lying down

Section 10- CHANGING DEGREE OF PAIN
- ☐ My pain is rapidly getting better
- ☐ My pain fluctuates but overall is definitely getting better
- ☐ My pain seems to be getting better but improvement is slow at present
- ☐ My pain is neither getting better or worse
- ☐ My pain is gradually worsening
- ☐ My pain is rapidly worsening

Pain Severity Scale

Rate the severity of your pain by checking one box on the following scale

No Pain	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

KINESIS HEALTH ASSOCIATES
NECK PAIN & DISABILITY INDEX QUESTIONNAIRE (Vernon Mior)

Patient Name: ______________________________ File #:_________ Date: _____________

PLEASE READ INSTRUCTIONS:

This Questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer each section and mark in only ONE box which applies to you. We realize you may consider that two of the statements in any one section to relate to you, but just mark the box which most closely describes your problem.

Section 1 – PAIN INTENSITY

- ☐ I have no pain at the moment
- ☐ The pain is very mild at the moment.
- ☐ The pain is moderate at the moment
- ☐ The pain is fairly severe at the moment
- ☐ The pain is very severe at the moment
- ☐ The pain is the worst imaginable at the moment.

Section 2 – PERSONAL CARE

- ☐ I can look after myself normally without causing extra pain
- ☐ I can look after myself normally but it causes extra pain
- ☐ It is painful to look after myself and I am slow and careful
- ☐ I need some help but manage my personal care
- ☐ I need help everyday in most aspects of self care
- ☐ I do not get dressed; I wash with difficulty and stay in bed.

Section 3 – LIFTING

- ☐ I can lift weights without extra pain
- ☐ I can lift heavy weights but it gives extra pain
- ☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned (e.g. on a table)
- ☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights, if they are conveniently positioned.
- ☐ I can only lift very light weights
- ☐ I can not lift or carry anything at all

Section 4- READING

- ☐ I can read as much as I want with no pain in my neck
- ☐ I can read as much as I want with a slight pain in my neck
- ☐ I can read as much as I want with moderate pain in my neck
- ☐ I can't read as much as I want because of moderate pain in my neck
- ☐ I can hardly read at all because of severe pain in my neck
- ☐ I cannot read at all.

Section 5- HEADACHES

- ☐ I have no headaches at all
- ☐ I have slight headache's which come infrequently
- ☐ I have moderate headaches which come infrequently
- ☐ I have moderate headaches which come frequently
- ☐ I have severe headaches which come frequently
- ☐ I have headaches almost all the time

Section 6- CONCENTRATION

- ☐ I can concentrate fully when I want to with no difficulty
- ☐ I can concentrate fully when I want to with slight difficulty
- ☐ I have a fair degree of difficulty in concentrating when I want to
- ☐ I have a lot of difficulty in concentrating when I want to.
- ☐ I have a great deal of difficulty in concentrating when I want to.
- ☐ I cannot concentrate at all

Section 7- WORK

- ☐ I can do as much work as I want to.
- ☐ I can only do my usual work,, but no more
- ☐ I can do most of my usual work, but no more
- ☐ I cannot do my usual work
- ☐ I can hardly do any work at all
- ☐ I can't do any work at all

Section 8- DRIVING

- ☐ I can drive my car without any neck pain
- ☐ I can drive my car as long as I want with slight pain in my neck
- ☐ I can drive my car as long as I want with moderate pain in my neck
- ☐ I can't drive my car as long as I want because of moderate pain in my neck
- ☐ I can hardly drive at all because of severe pain in my neck
- ☐ I can't drive my car at all.

Section 9- SLEEPING

- ☐ I have no trouble sleeping
- ☐ My sleep is slightly disturbed (less than 1 hr sleepless)
- ☐ My sleep is mildly disturbed (1-2 hrs sleepless)
- ☐ My sleep is moderately disturbed (3-2 hrs sleepless)
- ☐ My sleep is greatly disturbed(3-5 hrs sleepless
- ☐ My sleep is completely disturbed (5-7 hrs sleepless)

Section 10- RECREATION

- ☐ I am able to engage in all my recreation activities with no neck pain at all
- ☐ I am able to engage in all my recreation activities, with some pain in my neck
- ☐ I am able to engage in most but not all of my usual recreation activities because of pain in my neck
- ☐ I am able to engage in few of my usual recreation activities because of pain in my neck
- ☐ I can hardly do any recreation activities because of pain in my neck
- ☐ I can't do any recreation activities at all.

Pain Severity Scale

Rate the severity of your pain by checking one box on the following scale

No Pain	1	2	3	4	5	6	7	8	9	10	Excruciating Pain

Kinesis
Health Associates

Office Hours (Subject to Change)

	Dr. Jans Ellefsen	Dr. Emily Wiggin
Day	Time	Time
Monday	12:00pm – 7:30pm	12:00pm- 7:00pm
Tuesday	8:00am – 12:30pm	12:00pm- 7:00pm
Wednesday	12:00pm – 7:30pm	8:00am- 12:00pm
Thursday	8:00am – 12:30pm	12:00am- 7:00pm
Friday	11:00pm – 6:30pm	8:00am- 4:00pm
Saturday	-----------------------	---------------------

Patient Fees (Subject to Change)

	Visit	Adult Fee	Student Fee
Chiropractic	Initial consultation	***$98***	***$88***
	Re-Exam/Progress Exam	***$70***	***$65***
	Gait Scan	***$60***	***$50***
	Regular Follow Up Visit	***$55***	***$50***
	Acupuncture	***$65***	***$55***
Massage	1 hour massage	***$90***	***$80***
	45 minute massage	***$75***	***$65***
	½ hour massage	***$60***	***$50***
	1½ hour massage	***$125***	***$115***
Dietetics	Initial Consultation	***$85***	***$80***
	Food Record Analysis	***$70***	***$65***
	Follow-up Visits	***$45***	***$40***
Physiotherapy	Initial assessment	***$80***	***$75***
	Subsequent Sessions	***$70***	***$65***
	Laser Appointments	***$45***	***$40***
	Acupuncture	***$70***	***$65***
Osteopathy	Initial Assessment	***$110***	***$110***
	Subsequent Sessions	***$110***	***$110***

Payment: A fee totaling half the cost of service will be levied for missed appointments without cancellation notice 24 hours prior to the scheduled appointment.

I. Patients are required to pay by cash, VISA, MC, or debit card at each visit.
II. Patients are personally responsible for any fee(s) assessed to their accounts for any insurance letters or medical legal reports requested.
III. Receipts for any insurance and/or income tax purposes are issued each visit.
IV. The accumulation of fees is not permitted.

I have read the above, understand and agree to these terms.

____________________________ ____________________
Patient Signature **Date**

Date: | Kinesis File #:

Name

_______________ _______________ ________ Mr., Mrs., Ms., Dr.
Last First Middle Initial

Date of Birth **Day Month Year**	**Age**	**Gender** M F	

Address

#/Street_______________Apt #_____

City_______________

Province_______________Postal Code_______

Home Phone_______________

Email_______________

*By providing my email address I consent to receiving appointment reminders by email, as well as the occasional newsletter, weather cancellations, promotional info, etc.

Workplace and Address

Institution/Place _______________

Occupation/Student_______________

Street_______________

City_______________

Province__________Postal Code_______

Work Phone_______________

Contact Person in Case of Emergency

Name_______________Relationship_______________

Telephone #_______________

Previous Chiropractor

Name_______________Address_______________

Medical Doctor

Name_______________Address_______________

NS Health Card (MSI#) _______________

Whom may we thank for referring you to our clinic?

Name: _______________Newspaper Advertisement____________

Yellow Pages Listing__________ Other, please state_______________

***I grant permission to Kinesis Health Associates for sharing my confidential health information with my family doctor and other health professionals as necessary._______________

Patient Signature

Work Injury

Is this a Worker's Compensation Case? Yes_____ No_____ If Yes, Claim Number _______________

Date of Accident: _______________ Time of Accident_______________

Contact Name/Title at Work:_______________

Motor Vehicle Accident / Personal Injury Insurance Information

Date of Accident/Injury: _______________

Insurance Company:_______________ Claim Number: _______________

Adjuster:_______________ Telephone:_______________

Address: _______________ Fax: _______________

____

BLUE CROSS SUBSCRIBERS **Policy Number**:_______________

Identification Number:_______________ **Effective Date**: _______________

*****IMPORTANT: By signing below you acknowledge that you are responsible for all charges if your WCB or Insurance Claim is not accepted or it is discontinued**

Signature: _______________ **Date:** _______________