

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

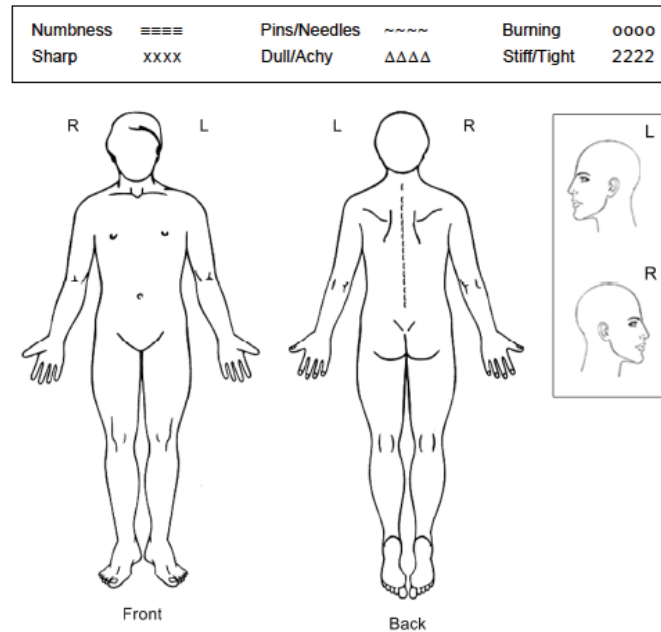
5/7

- 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

6/7

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:



Health Status Survey

7/7

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

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