OKANAGAN HEALTH & PERFORMANCE

CHIROPRACTIC, MASSAGE THERAPY, KINESIOLOGY, PHYSIOTHERAPY, ACUPUNCTURE, TRADITIONAL CHINESE MEDICINE & NATUROPATHIC MEDICINE

104-1100 Lawrence Ave, Kelowna, BC, V1Y 6M4 **(250) 860-6295**

www.ohpkelowna.com Fax:(250) 860-2424

PERSONAL INFORMATION

First Name _____ Initial _____ Last Name _____ Care Card # _____

Birthdate: MM _____ DD _____ YY _____ Age _____ Gender: M _____ F _____

Address _____City _____ Prov _____ Postal Code _____

Phone: Home _____ Work _____ Cell _____

Email _____(for appt reminders & recalls)

Preference for appointment reminders _____ Email AND/OR _____ Text

Time before appointment (please check as many as you'd like) ___ 48hrs ___ 24hrs ___ 3hrs ___2hrs ___ 1hr ___ 30mins

Permission to send monthly newsletters: _____ YES _____ NO

Type of Work _____ Employer _____

Marital Status: S___ M ___ D___ Sep ___ W ___ Number of children _____

Emergency Contact _____ Phone Number _____

How did you hear about us? Referred by: _____ Phone book ___ Sign ___ Radio ___ Other (specify)_____

HEALTH CARE COVERAGE/CLAIM INFORMATION

Is this a work related injury/accident (WCB) or a motor vehicle related injury (ICBC)? If yes: Claim # _____

Are you claiming through the Department of Veteran Affairs (DVA, RCMP, etc)? If yes: Claim # _____

Do you have an Extended Health Plan through your Employer or Privately? If yes: Who? _____

PREVIOUS CHIROPRACTIC CARE

Have you had previous chiropractic care? Y___ N ___ Results: Excellent ___ Good ___ Fair ___ Poor ____

Name of Chiropractor _____ Date last seen _____

MEDICAL HISTORY AND INFORMATION

Your Medical Practitioner's Name: _____ Phone: _____

Date last seen _____ Reason for visit _____ Recent medical testing: Xrays___ Blood test ____ Other____

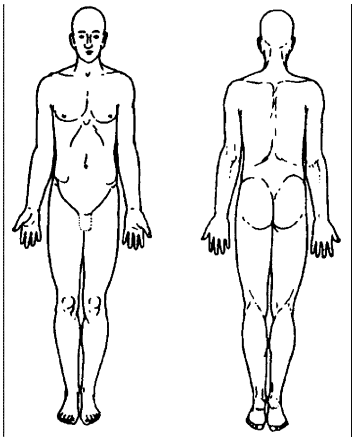
Are you presently taking medication/supplements? If yes, what _____

Your Family History; What Relation to you?	Your History			Reason for visit today:
❑ Cancer _____	❑ Aneurysm	❑ Cancer	❑ Headaches	❑ Pain
❑ Stroke _____	❑ Stroke/DVT	❑ Blood Disorder	❑ Dizziness	❑ Headaches
❑ Diabetes _____	❑ Epilepsy	❑ High/Low BP	❑ STD	❑ Dizziness
❑ Hypertension _____	❑ Heart cond.	❑ Bone Disease	❑ Pregnancy	❑ Stiffness
❑ Arthritis _____	❑ Osteoporosis	❑ Neurological disease	❑ Arthritis	❑ General Checkup
❑ Other _____	❑ Diabetes		❑ Other _____	❑ Other _____

Have you ever had … Motor vehicle accidents, sporting accidents, personal/work accidents, fractures, surgery, dislocations?

When _____ **Give details** _____

YOUR RELEVANT HISTORY FOR TODAY'S EXAMINATION



Please indicate your symptoms on the **diagram** using the appropriate symbol:
Aching: A Burning: B Numbness: N Stabbing: S Throbbing: T

How did your symptoms start? □suddenly □gradually □after a fall □accident □lifting □ bending □after illness □woke with it □other_____

When are the symptoms worse? □in the morning □during the day □end of the day □in bed □during the night □all the time □other_____

Rate your pain by notching on the line (no pain) 0_____10 (worst pain)
Rate your disability by notching on the line (none) 0_____10 (disabled)
(**1** not impaired doing normal activities, **5** activities with difficulty, **10** can not function)

What makes it better? Lying down, sitting, standing, walking, movement, exercise, heat, ice, massage, medication_____

What makes it worse? Lying down, sitting, standing, walking, movement, exercise, bending, lifting, twisting, Other _____

Have you had any other type of treatment for this injury Yes _____ No _____ Was it helpful? Yes _____ No _____

Please circle treatment received: Physiotherapy Massage Therapy Acupuncture Medication Chiropractic Care

Other _____

Please provide details of your treatment and the name of the therapist _____

_____

Please list any **X-Rays** or other tests that have been done for this condition: _____

Do you participate in a **regular exercise program, or sporting activity**? What _____ How often _____

Do you have any regular **past-times, hobbies, passions** (i.e. gardening, sewing, etc)? What _____ How often _____

Please rate your stress level by notching on the line (no stress) 0_____10 (most stressed)

What is the main source of your stress? _____

Do you participate in any **health promoting activities** such as **meditation, dieting, etc?** What _____ How often _____

Do you **smoke?** If yes, how much?_____ Do you **drink alcohol?** If yes, how much?_____

Has your **body weight** changed recently? Gained _____ Lost ____ No change ____

Are you satisfied with your current fitness level? Y ____ N ____

Are there any things about yourself that you would like to change/improve? (i.e. quit smoking, lose weight, improve fitness, reduce stress, etc) Please explain _____

What is preventing you from achieving your **goals**? _____

Is there anything else that you are concerned about or would like **advice** about? _____

Please Note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient. I understand that payment for services rendered is due at the time of service and 1.5% will be compounded monthly on any outstanding accounts for an annual interest rate of 19.56%. I authorize the clinic and its associated chiropractors to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated chiropractors to communicate with my referring MD as deemed necessary for my beneficial treatment. I give permission for my health records at OHP to be shared with other health care practitioners here at OHP. I also give permission for the practitioners here at OHP to discuss my health concerns. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. I agree to assign my Medical Services Plan reimbursement for Chiropractic services over to Okanagan Health & Performance (if applicable). If I have provided my email to OHP either on this form or verbally, I give permission to be emailed for appointment reminders, recall notifications and newsletters as they are sent out.

Patient Signature *(**or** Legal Guardian if patient is under 16)* _____

Date _____ Witness _____