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

Dear Patient, welcome to **Okanagan Health & Performance**. Thank you for entrusting us with your health.

PERSONAL INFORMATION

Child's First Name _____ Initial _____ Last Name _____ Care Card # _____

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

Address _____City _____ Prov _____ Postal Code _____

Parent's Name(s) _____Phone: (H)_____ (W)_____ (C) _____

Work _____ Emergency Contact _____ Phone _____

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

Parent's Marital Status: _____ Number of children _____ Names and ages _____

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

HEALTH CARE COVERAGE/CLAIM INFORMATION

Is this a motor vehicle related injury (ICBC)? Yes ___ No ___ If yes, claim # _____

PREVIOUS CARE

Has your child been to another practitioner for this condition? _____

Previous chiropractic care ___Y ___ N Name of chiropractor _____ Phone _____

Date last seen _____ Treatment _____ Results: ___ Good ___ Fair ___ Poor

HEALTH HISTORY AND INFORMATION

Birth Weight _____ Current Weight _____ Height/Length _____

Type of Birth: _____ Length of Delivery _____ Baby's APGAR score _____

Location of Birth: ___ hospital ___ home ___ birthing centre _____ other

Name of Doctor or midwife for delivery: _____

Birth trauma, infection, jaundice, etc. _____

Congenital Anomalies/childhood diseases _____

Baby's Feeding Habits : _____ breast _____ bottle ___ formula

Current Diet _____

Quality of Sleep _____ Number of Hours/night _____

Are Bowel movements regular? ___ yes ___ no. If no, explain _____

Medical Practitioner's Name _____ Phone _____

Date last seen _____ Reason for visit/comments _____

Has the child been on any medications or antibiotics yet? _____

Current Medications/Vitamins _____

Immunization/Vaccinations _____

What is your reason for seeking care at OHP? _____

_____

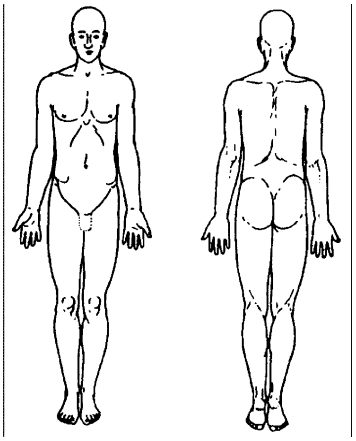
What is this affecting that is MOST important in your child's life? _____

_____

AFFECTED SYMPTOMS & CONDITIONS

__Anemia __Arthritis __Asthma __Bedwetting __Bone Disease	__Colds/Flu __Colic __Diabetes __Digestive Disorders __ Dizziness	__ Ear Infection __ Heart Trouble __Hyperactivity/ADD __Muscle jerking __Neuritis	__Poor appetite __Sinus Trouble __Tuberculosis __ Other _____

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 _____

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.

Parent's Signature: _____

Date _____ Witness _____