The Performance Health Centre

CONFIDENTIAL PATIENT INFORMATION

Name ______________________ Today's Date - d/m/y ____________ Age ________

Address ______________________ City ______________ Postal code ____________

Date of birth – d/m/y ______________ Occupation ______________________

OHIP # ______________________ Version code ______ Expiry date ____________

Home phone ____________ Cell phone ____________ Business phone ____________

E-mail address ______________________ Referred by ____________

How did you hear about us?

Internet ☐ Sandwich board ☐ Gift Certificate ☐ Flyer ☐ Other (Please specify) ______________

Would you like to receive our month newsletter about health tips and specials? Yes ☐ No ☐

Do you have Extended Health Care: Yes ☐ / No ☐ Company Name ______________ Policy # ____________

General Health Info

Major complaint ______________________

How long have you had this condition? ________ What **aggravates** this condition? ______________

Is it: Getting worse ☐ Remaining constant ☐ Comes and goes ☐ Getting better ☐

Have you had this or a **similar problem** in the past? ______________________

Previous diagnosis and treatment for the present condition ______________________

Other complaints ______________________

List previous surgery ______________________

List previous injuries ______________________

Do you currently take: Pain killers ☐ Birth control ☐ Muscle relaxants ☐ Other ______________

Do you wear: Heel lifts ☐ Arch supports ☐ Sole lifts ☐

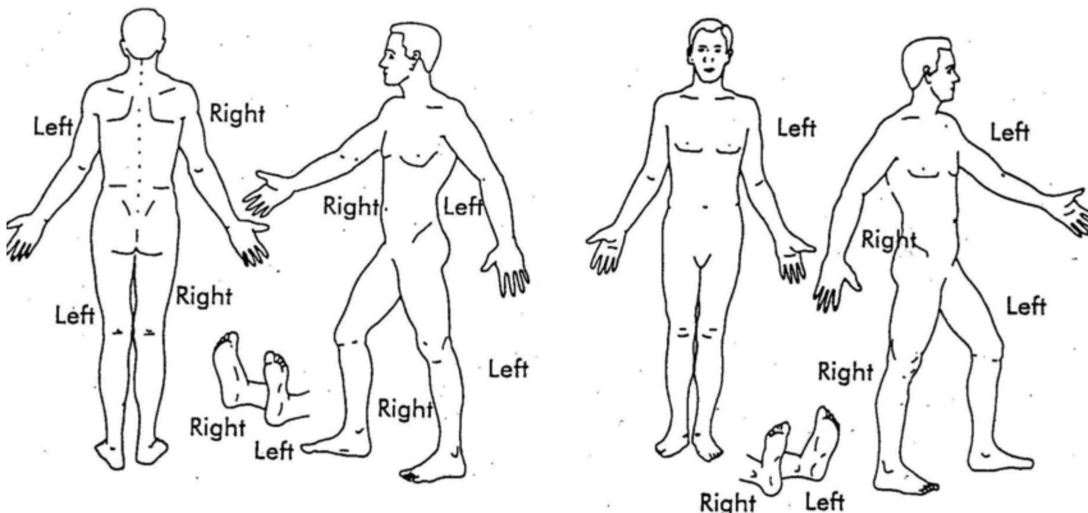
Name of family doctor ______________________ Phone # ______________

Address of family doctor ______________________

Family Health History Information:

Name	Relation	Past and present health problems

Please mark your area of **pain or concern** in the figure below.



Have you utilized one of the following therapies?	Chiropractic ☐	Naturopathy ☐	Massage Therapy ☐	Acupuncture ☐
	Active Release - ART ☐	Graston ☐	Shockwave ☐	Traction ☐
For what **condition**?	_______________	______________	______________	_____________

HEAD AND NECK	**Previously**	**Currently**
History of Headache	[ ]	[ ]
History of Migraine	[ ]	[ ]
EYES / EARS		
Vision loss	[ ]	[ ]
Vision problems	[ ]	[ ]
Hearing loss	[ ]	[ ]
Ear problems	[ ]	[ ]

RESPIRATORY	**Previously**	**Currently**
Chronic Cough	[ ]	[ ]
Asthma	[ ]	[ ]
Shortness of Breath	[ ]	[ ]
Bronchitis	[ ]	[ ]
Emphysema	[ ]	[ ]
Other	[ ]	[ ]

Family history of the above YES ☐ NO ☐ Not Sure ☐

SURGICAL IMPLANTS		
Any wires, pins,	[ ]	[ ]

Artificial joints or special equipment: __________________

____

INFECTIONS	**Previously**	**Currently**
Herpes	[ ]	[ ]
Hepatitis	[ ]	[ ]
Tuberculosis	[ ]	[ ]
HIV. Aids	[ ]	[ ]
Skin conditions	[ ]	[ ]

OTHER CONDITIONS	**Previously**	**Currently**
Loss of sensation, where?	[ ]	[ ]
Diabetes: onset__________	[ ]	[ ]
Allergies: ______________	[ ]	[ ]
Cancer: ______________	[ ]	[ ]
Epilepsy	[ ]	[ ]
Skin condition ___________	[ ]	[ ]
Arthritis	[ ]	[ ]

Family history of the above YES ☐ NO ☐ Not Sure ☐

SKIN	**Previously**	**Currently**
Skin condition	[ ]	[ ]
Type: ________________		
Bruise easily	[ ]	[ ]
Plantar warts	[ ]	[ ]
Rashes	[ ]	[ ]
FEMALE		
Menopausal problems	[ ]	[ ]
Menstrual problems	[ ]	[ ]
C-section	[ ]	[ ]
Pregnant – due date: ______	[ ]	[ ]

CARDIOVASCULAR		
High blood pressure	[ ]	[ ]
Low blood pressure	[ ]	[ ]
Congestive heart failure	[ ]	[ ]
Heart disease	[ ]	[ ]
Heart attack	[ ]	[ ]
Pacemaker	[ ]	[ ]
Stroke / CVA	[ ]	[ ]
Phlebitis	[ ]	[ ]
Varicose veins	[ ]	[ ]

Family history of the above YES ☐ NO ☐ Not Sure ☐

OTHER CONDITIONS	**Previously**	**Currently**
Difficult Digestion	[ ]	[ ]
Liver	[ ]	[ ]
Hemophilia	[ ]	[ ]
Kidney	[ ]	[ ]
Sinus	[ ]	[ ]
Gall bladder	[ ]	[ ]
Diabetes (type?)	[ ]	[ ]
Rheumatoid Arthritis	[ ]	[ ]
Osteoarthritis	[ ]	[ ]
	[ ]	[ ]
	[ ]	[ ]
	[ ]	[ ]

Family history of the above YES ☐ NO ☐ Not Sure ☐

Date of last **chiropractic** visit ___________________________ Date of last **spine X-ray** ________________________________

Date of last **MD** visit ___________________________ Date of last **chest X-ray** ________________________________

Date of Initial Health History __________ Update 1 _____________ Update 2 _____________ Update 3 ______________

For Women Only

Are you pregnant? Yes ☐ / no ☐ / maybe ☐ When was your last period? ____________________________________

I understand that a failure to give a 24 hour cancelation notice on all appointments will result in a full service charge. ___________*(please initial)*

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment to the Doctor.

Signature ____________________________________ **Date** _________________________________