Rehab Connections
Injury & Chiropractic Wellness

Confidential Patient Health Record

Today's Date (mm/dd/yyyy): ___/___/_____

How did you hear about us? ☐ Family _____ ☐ Friend _____ ☐ TV ad _____ ☐ Drove by
☐ Close to home/work ☐ Dr. _____ ☐ Yellow pages, which one? _____ ☐ Newspaper _____ ☐ Hospital

Personal Information

Title: ☐ Mr. ☐ Ms. ☐ Mrs. Last:_____ First:_____ File#: _____
Birth Date (mm/dd/yyyy): ____/____/_____ Age:_____ Sex: Male / Female
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Address: _____ Apt # _____
City: _____ Province: _____ Postal Code: _____
Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ ext _____
Cell Phone: (_____) _____-_____ Email Address: _____
Spouses Name: _____ Spouses Work / Cell Phone: _____
Children (Names and Ages): _____

Emergency Contact

Name:_____ Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other _____
Home Phone: (_____) _____-_____ Work / Cell Phone: (_____) _____-_____

Employment Information

Business Name: _____
Occupation/Job Title: _____ Job Description _____
Phone (if different): (_____) _____-_____ Employer's Email Address: _____

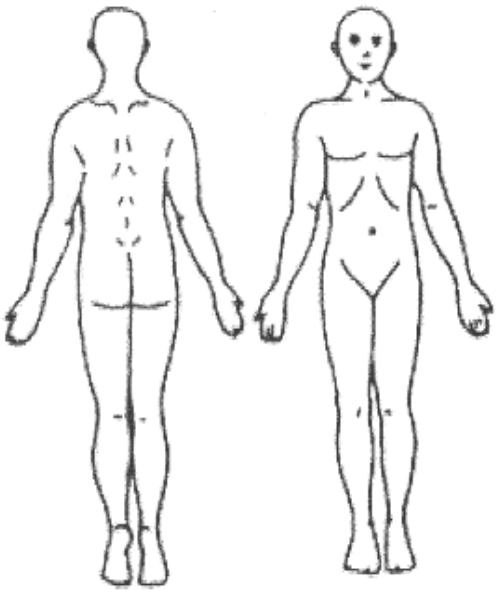
Current Health Condition

Why you are you here / what brought you here today?:_____
_____

Use the letters BELOW to indicate the TYPE and LOCATION of your sensations right now.

PLEASE LABEL ON THE DIAGRAM THE AREA OF DISCOMFORT
→ → → → → → →

Key: A=Ache B=Burning N = Numbness
P=Pins & Needles S=Stabbing



When did this Condition BEGIN (mm/dd/yyyy)? _____/_____/_____

Has it ever occurred before? ☐ Yes ☐ No. When? _____

Is the Condition: ☐ Auto Related ☐ Job Related ☐ Home Injury

☐ Slip or Fall ☐ Lifting ☐ Slept Wrong ☐ Unknown Cause ☐ Other

Explain: _____

_____

Date of Accident: _____ Time of Accident: _____ am /pm

Condition/Pain STARTED on what Date: _____

Do you SUFFER with ANY OTHER Condition than which you are now consulting us?

_____

_____

Patient Name: _____ **File #:**_____ **Today's Date (mm/dd/yyyy):**_____

Review of Systems (ROS) -Below is a list of symptoms that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as the problems can affect your overall care.

Constitutional: ☐ I DENY having or have had any of the symptoms or problems listed below.

☐ chills ☐ fatigue ☐ fever ☐ weight gain ☐ night sweats ☐ weight loss ☐ daytime drowsiness

Eyes/Vision: ☐ I DENY having any of the symptoms or problems listed below.

☐ blindness ☐ blurred vision ☐ cataracts ☐ change in vision ☐ double vision ☐ eye pain ☐ field cuts
☐ glaucoma ☐ itching ☐ photophobia ☐ tearing ☐ wear glasses/contacts

Ears, Nose and Throat: ☐ I DENY having any of the symptoms or problems listed below.

☐ bleeding ☐ dentures ☐ difficulty swallowing ☐ discharge ☐ dizziness ☐ ear drainage ☐ ear pain
☐ fainting ☐ frequent sore throats ☐ headaches ☐ hearing loss ☐ history of head injury ☐ hoarseness
☐ loss of sense of smell ☐ nasal congestion ☐ nosebleeds ☐ rhinorrhea (runny nose) ☐ sinus infections
☐ snoring ☐ postnasal drip ☐ sore throat ☐ tinnitus (ringing in ears) ☐ TMJ problems

Respiration: ☐ I DENY having any of the symptoms or problems listed below.

☐ asthma ☐ cough ☐ coughing up blood ☐ sputum production ☐ shortness of breath ☐ wheezing

Cardiovascular: ☐ I DENY having any of the symptoms or problems listed below.

☐ angina (chest pain or discomfort) ☐ claudication (leg pain/ache) ☐ heart murmur ☐ sleep apnea
☐ high blood pressure ☐ orthopnea (difficulty breathing lying down) ☐ palpitations ☐ varicose veins
☐ paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath ☐ shortness of breath with exertion or exercise

Gastrointestinal: ☐ I DENY having any of the symptoms or problems listed below.

☐ abdominal pain ☐ belching ☐ black - tarry stools ☐ constipation ☐ diarrhea ☐ difficulty swallowing
☐ heartburn ☐ hemorrhoids ☐ indigestion ☐ jaundice ☐ nausea ☐ rectal bleeding
☐ abnormal stool caliber ☐ abnormal stool color ☐ abnormal stool consistency ☐ vomiting ☐ vomiting blood

Female: ☐ I DENY having any of the symptoms/problems and/or using any of the items listed below.

☐ birth control ☐ breast lumps/pain ☐ cramps ☐ burning urination ☐ frequent urination ☐ hormone therapy
☐ irregular menstruation ☐ pregnancy ☐ urine retention ☐ vaginal bleeding ☐ vaginal discharge

Male: ☐ I DENY having any of the symptoms or problems listed below.

☐ burning urination ☐ erectile dysfunction ☐ frequent urination ☐ hesitancy/dribbling ☐ prostate problem

Endocrine: ☐ I DENY having any of the symptoms or problems listed below.

☐ cold intolerance ☐ diabetes ☐ excessive appetite ☐ excessive hunger ☐ excessive thirst ☐ goiter
☐ abnormal frequency of urination ☐ hair loss ☐ heat intolerance ☐ unusual hair growth ☐ voice changes

Skin: ☐ I DENY having any of the symptoms or problems listed below.

☐ changes in nail texture ☐ changes in skin color ☐ hair growth ☐ hair loss ☐ hives
☐ history of skin disorders ☐ itching ☐ paresthesias ☐ rash ☐ skin lesions / ulcers ☐ varicosities

Nervous System: ☐ I DENY having any of the symptoms or problems listed below.

☐ dizziness ☐ facial weakness ☐ limb weakness ☐ headache ☐ loss of consciousness ☐ loss of memory ☐ numbness
☐ seizures ☐ slurred speech ☐ sleep disturbance ☐ stress ☐ stroke ☐ tremor ☐ unsteadiness of gait/loss of balance

Psychologic: ☐ I DENY having any of the symptoms or problems listed below.

☐ anhedonia ☐ anxiety ☐ loss or change in appetite ☐ behavioral change ☐ bi-polar disorder
☐ confusion ☐ convulsions ☐ depression ☐ insomnia ☐ memory loss ☐ mood change

Allergy: ☐ I DENY having any of the symptoms or problems listed below.

☐ anaphalaxis ☐ food intolerance ☐ itching ☐ acute nasal congestion ☐ chronic nasal congestion ☐ rash ☐ sneezing

Hematologic: ☐ I DENY having any of the symptoms or problems listed below.

☐ anemia ☐ bleeding ☐ blood clotting ☐ blood transfusion ☐ bruising easily ☐ fatigue ☐ lymph node swelling

Patient Name: _____ File #:_____ Today's Date (mm/dd/yyyy):_____

Past Family Social Health History (PFSH) – Complete carefully as these problems can affect your overall course of care.

A. PAST HEALTH HISTORY (PFSH)

Previous Care for this Condition: ☐ I have not previously seen a doctor for this condition OR Fill in BELOW

Have you seen other doctors for THIS CONDITION? ☐ Yes ☐ No. If yes, Who? (Name) _____

Type of Treatment: _____ Was the treatment beneficial in resolving condition? ☐ Yes ☐ No

Explain: _____

Previous Chiropractic Care: ☐ I have not previously seen a Chiropractor OR Fill in the information BELOW.

Doctor's Name: _____ Location: _____ Date of Last Visit: _____

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication (list others on back of page)	Dosage	For What Condition?	How long / Since when?

Childhood Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

☐ ADD ☐ anemia ☐ cerebral palsy ☐ depression ☐ eczema ☐ headache ☐ measles ☐ rash ☐ seizure
☐ allergies ☐ asthma ☐ chicken pox ☐ diabetes ☐ fetal drug ☐ hepatitis ☐ mumps ☐ scoliosis ☐ spina bifida
/hayfever ☐ bedwet ☐ crohn's/colitis ☐ ear infections ☐ food allergy ☐ HIV ☐ psoriasis ☐ sickle cell disorder

Adult Illness(es): LIST all health conditions. CIRCLE all CURRENT conditions.

☐ ADD	☐ crohn's/colitis	☐ eye problems	☐ lung disease	☐ scoliosis
☐ alzheimers	☐ CVA (stroke)	☐ fibromyalgia	☐ lupus erythema (discoid)	☐ seizures
☐ anemia	☐ cystic kidney disease	☐ heart disease	☐ lupus erythema (systemic)	☐ shingles
☐ arthritis	☐ depression	☐ hepatitis	☐ multiple sclerosis	☐ STD's (unspecified)
☐ asthma	☐ diabetes (insulin dep)	☐ HIV	☐ parkinson's disease	☐ suicide attempt(s)
☐ cancer	☐ diabetes (non insulin)	☐ hypertension-high BP	☐ pneumonia	☐ thyroid problems
☐ cerebral palsy	☐ eczema	☐ influenzal pneumonia	☐ psoriasis	☐ vertigo
☐ chicken pox	☐ emphysema	☐ liver disease	☐ psychiatric problems	☐ other

Doctor: Are Child/Adult Illnesses listed contributory to the CURRENT Condition? ☐ yes or ☐ no.

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

☐ angioplasty	☐ cardiac catheter	☐ D & C	☐ coronary bypass	☐ hysterectomy	☐ laminector	☐ rotator cuff
☐ appendectomy	☐ carpal tunnel	☐ dental surg	☐ hemorrhoidectomy	☐ joint replace	☐ mastectomy	☐ spinal fusion
☐ C-section	☐ cosmetic	☐ gall bladder	☐ hernia repair	☐ knee repair	☐ pacemaker	☐ tonsilectomy

Injury (ies): Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

☐ back injury	☐ fall (severe)	☐ head injury	☐ joint injury	☐ soft tissue injury (mild)
☐ broken bones	☐ fracture	☐ no loss of consciousness	☐ laceration (severe)	☐ soft tissue injury (moderate)
☐ disability(ies)	☐ industrial accident	☐ loss of consciousness	☐ motor vehicle accident	☐ soft tissue injury (severe)

B. FAMILY HEALTH HISTORY (PFSH)

Family History: Mark all that apply below. List any specific conditions past or present after has/had:

father	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
mother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
paternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
paternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
maternal grandfather	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
maternal grandmother	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
son (s) / daughter(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had:_____
brother(s) / sister(s)	☐ alive	☐ deceased	☐ normally developed	☐ no significant disease	☐ has/had: _____

Patient Name: _____ **File #:**_____ **Today's Date (mm/dd/yyyy):**_____

C. SOCIAL HEALTH HISTORY / Activities of Daily Living (PFSH)

(i) Lifestyle Habits:

Alcohol: ☐ **Social Consumption** ☐ **Beer** ___ **drinks/wk** ☐ **Liquor**___ **drinks/wk** ☐ **Wine** _____ **drinks/wk**
Substance: **IV used** ☐ Yes ☐ No ☐ **Drugs for** ____**yrs** ☐ **No drugs since** _____
Tobacco: ☐ Yes ☐ No ☐ **Smoked for** ___**yrs** ☐ **Currently** _____ **packs/day**
Diet: ☐ **Special Diet** _____ ☐ **Appetite Poor** ☐ **# Meals** ____ **/day** ☐ **Water** ____ **L/day**
Supplements (List all current): _____

Sleep: **Hours:** ____ **/night** ☐ **Sleep Poor** **Mattress:** **firm/medium/soft** **new/<5 yrs/<10 yrs**
Position: Right side/Left side/back/stomach **Pillow:** **reg/cervical/body/none** **1/2/>2**

(ii) Daily Activities: Effects of Current Condition on Performance

Bending:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Care –Infirm Family:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Carrying Groceries:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Change Posn–Sit-Stand:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Climb Stairs:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Driving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Extended Computer Use:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Feeding:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Household Chores:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Kneeling:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lift Children:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lifting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Reading (Concentration):	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Bathing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Dressing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Shaving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sleep:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Sitting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Standing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Walking:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Yard Work:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Other: _____	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform

(iii) Employment Details:

Occupation/Job Title: _____ **Work:** _____ **hrs / day or week**
Description of Work: _____
Job Classification: ☐ **Sedentary** (<5lbs) ☐ **Light** (5-20lbs) ☐ **Moderate** (20-50lbs) ☐ **Heavy** (>50 lbs)
Lifting Frequency: ☐ **Constant** (67-100%/day) ☐ **Frequent** (33-66%/day) ☐ **Occasional** (0-32%/day)
Lifting Postures: ☐ **with Arms** ☐ **High Near** ☐ **from Knee** ☐ **Off Posture** ☐ **from Torso**
Work Activity Postures: (hrs/day)
☐ **bending:** ___**h/d** ☐ **climbing:**___**h/d** ☐ **kneeling:**____**h/d** ☐ **pulling:** ____**h/d** ☐ **pushing:** ____**h/d**
☐ **reaching:** ___**h/d** ☐ **sitting:** ____**h/d** ☐ **standing:** ___**h/d** ☐ **twisting:** ___**h/d** ☐ **walking:** ___**h/d**
Repetitive Activities: (hrs/day)
☐ **assembly/fine manipulation:** ___**h/d** ☐ **computer use/typing:** _____ **h/d** ☐ **grasping:** _____ **h/d**
☐ **hand tool use:** _____ **h/d** ☐ **operation of machinery controls:** ___ **h/d** ☐ **phone use:** ____**h/d**
Condition's Effect On Job Performance:
☐ **Mild** painful/can do ☐ **Mod** painful/limited ability ☐ **Mod/Sev** limited duty ☐ **Sev** no limited duty ☐ **Sev** can't do limited duty

(iv) Recreational Activity:

Effect of Current Condition of Performance

_____	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
_____	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform

Patient Name: _____ **File #:**_____ **Today's Date (mm/dd/yyyy):**_____

Car Injury / Motor Vehicle Accident (MVA)

Car Injury:

Have you filed a claim with your car insurance company? ☐Yes ☐ No Accident Date:_____ Time: _____am/pm

Insurance Co.: _____ **Policy #** _____
Insurance Co. Phone #: (_____) _____-_____ **Adjuster:** _____
Claim #: _____

If this is a motor vehicle accident injury, please ask for Auto Insurance Forms. (☐ Yes, more forms…)

Financial Responsibility – Your financial commitment and time commitment to your recommended care will help to ensure progressive recovery and overall success in healing.

Financial Information:

Who Is Responsible For Your Bill? YOU and… (mark appropriate box(es))

☐ **Myself ONLY** ☐ **Spouse** ☐ **Auto Insurance** ☐ **Other (be specific):**_____

Types Of Care (Relief – Corrective – Wellness)

Most patients that come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain and/or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program.

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying the floor that is getting wet from a leak, but not fixing the leak.

Corrective Care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

☐ **Relief Care** ☐ **Corrective Care** ☐ **Check here if you want the Doctor to select the type of care appropriate for your condition**

_____ _____ _____
Signature of Patient (or Guardian) **Print Name of Patient** **Date**

Informed Consent for Examination

Consent to Examination:

I hereby request and consent to a physical examination by doctors and/or staff of Rehab Connections (1572292 Ontario Inc.). I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate treatment, any fees for professional services rendered to me will be immediately due and payable.

_____ _____ _____
Signature of Patient (or Guardian) **Print Name of Patient** **Date**

_____ _____ _____
Signature of Clinic Staff **Print Name of Clinic Staff** **Date**