**Dr. Irvin Lee-Ying**
**Dr. Wendy Kwok**

300 – 2525 Woodview Drive SW
Calgary, Alberta T2W 4N4
T: 403.238.7700 F: 403.238.7808
W: http://woodbinechiropractic.ca
E: info@woodbinechiropractic.ca

# Welcome!

Thank you for choosing us.

Please ask if you have any questions or concerns.

*Your Health is in good hands!*

## 1 PATIENT INFORMATION

LAST NAME | FIRST NAME | MIDDLE | PREFERS TO BE CALLED

GENDER at BIRTH | PRONOUNS | DOB (DD/MMM/YYYY) | AGE | AB HEALTH NO.

STREET ADDRESS | CITY, PROVINCE | POSTAL CODE

MARITAL STATUS | CHILDREN? | HOW MANY?

HOME PHONE | MOBILE PHONE | WORK PHONE

EMAIL (Optional – Email used for your profile and to book online appointments) | HOW DID YOU HEAR ABOUT US?

## 2 EMERGENCY CONTACT

NAME 1 | RELATIONSHIP | PHONE

NAME 2 (OPTIONAL) | RELATIONSHIP | PHONE

## 3 INSURANCE INFORMATION

PRIMARY COMPANY | POLICY NO. | ID

PRIMARY MEMBER NAME | DOB (DD/MMM/YYYY)

SECONDARY COMPANY | POLICY NO. | ID

PRIMARY MEMBER NAME | DOB (DD/MMM/YYYY)

## 4 MEDICAL DOCTOR INFORMATION

NAME | PHONE NO.

ADDRESS | CITY, PROVINCE | POSTAL CODE

## 5 CHIROPRACTOR INFORMATION

NAME | PHONE NO.

ADDRESS | CITY, PROVINCE | POSTAL CODE

## 6 EMPLOYMENT INFORMATION

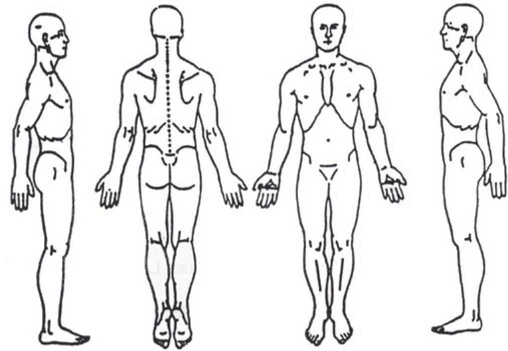
| OCCUPATION | COMPANY NAME | |
|---|---|---|
| ADDRESS | CITY, PROVINCE | POSTAL CODE |

## 7 TYPE OF INJURY

| | | |
|---|---|---|
| Did the current injury occur at your workplace? | YES | NO |
| Did the current injury occur as a result of a Motor Vehicle Accident? | YES | NO |

## 8 HEALTH CONCERNS

What is bothering you? Please describe the reason for your visit today.
Mark on the diagram:



Please describe **any other medical problems** such as surgeries, injuries, accidents, and falls that you have had in the past. Please list any surgeries or treatments for those problems.

## 9 LIFESTYLE

List any prescription or over-the-counter medications you are currently taking:

| MEDICATION | CONDITION | MEDICATION | CONDITION |
|---|---|---|---|
| 1. | | 4. | |
| 2. | | 5. | |
| 3. | | 6. | |

Please list any allergies or sensitivities:

| | | | | |
|---|---|---|---|---|
| How many hours of television do you watch a day? | ☐ <1 | ☐ 1-2 | ☐ 3-5 | ☐ >5 |
| How many hours a day do you use a computer at work or home? | ☐ <1 | ☐ 1-2 | ☐ 3-5 | ☐ >5 |
| How many hours a day do you drive / ride in a vehicle? | ☐ <1 | ☐ 1-2 | ☐ 3-5 | ☐ >5 |
| How many servings of **alcohol** do you drink weekly? | ☐ 0 | ☐ 1-2 | ☐ 3-5 | ☐ >5 |
| How many servings of **coffee** do you drink weekly? | ☐ <1 | ☐ 1-2 | ☐ 3-5 | ☐ >5 |
| How many servings of **soft drinks** do you drink weekly? | ☐ <1 | ☐ 1-2 | ☐ 3-5 | ☐ >5 |

How often do you exercise? | Type of exercise?

Do you smoke? YES NO | Packs / week: | Years smoking:

## 10 PERSONAL MEDICAL HISTORY

Check the following conditions that **currently** pertain to you:

| | | | | |
|---|---|---|---|---|
| ☐ Cancer | ☐ Asthma | ☐ Neck pain | ☐ Acid reflux | ☐ Prostate problems |
| ☐ Diabetes | ☐ Emphysema | ☐ Low back pain | ☐ Bladder problems | ☐ Epilepsy |
| ☐ Heart problems | ☐ COPD | ☐ Stomach problems | ☐ Irritable bowel | ☐ Fibromyalgia |
| ☐ Stroke | ☐ High/Low blood press. | ☐ Ulcer | ☐ Anemia | ☐ HIV / AIDS |
| ☐ Hypothyroid | ☐ Headache | ☐ Hepatitis | ☐ Chronic fatigue | ☐ Multiple Sclerosis (MS) |

Other conditions not listed above:

## 11 FAMILY HISTORY

| | RELATIONSHIP TO YOU | | RELATIONSHIP TO YOU |
|---|---|---|---|
| Cancer | | Headaches | |
| Diabetes | | Thyroid disorder | |
| Heart disease | | Depression | |
| Stroke | | Blood disorder | |
| High blood pressure | | Epilepsy | |
| High cholesterol | | Other | |

## 12 NEUROLOGICAL

Have you ever been knocked unconscious, had memory lapses, or injured your head or neck? YES | NO If yes, please explain:

Please circle a corresponding number to indicate the current severity of your symptoms.

Rate your symptoms according to this criteria: **0 = None** **1-2 = Mild** **3-4 = Moderate** **5-6 = Severe**

| Symptom | | | | | | | | Symptom | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| "Pressure in head" | 0 | 1 | 2 | 3 | 4 | 5 | 6 | "Don't feel right" | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Headaches | 0 | 1 | 2 | 3 | 4 | 5 | 6 | Difficulty concentrating | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Foggy feeling | 0 | 1 | 2 | 3 | 4 | 5 | 6 | Difficulty remembering | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Neck pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | Fatigue / low energy | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Nausea / vomiting | 0 | 1 | 2 | 3 | 4 | 5 | 6 | Confusion | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Dizziness | 0 | 1 | 2 | 3 | 4 | 5 | 6 | Drowsiness | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Blurred vision | 0 | 1 | 2 | 3 | 4 | 5 | 6 | Trouble falling asleep | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Balance problems | 0 | 1 | 2 | 3 | 4 | 5 | 6 | More emotional | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Light sensitivity | 0 | 1 | 2 | 3 | 4 | 5 | 6 | Irritable | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Noise sensitivity | 0 | 1 | 2 | 3 | 4 | 5 | 6 | Sadness | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Feeling slow | 0 | 1 | 2 | 3 | 4 | 5 | 6 | Nervous / anxious | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Other: | | | | | | | | Other: | | | | | | | |

| | | |
|---|---|---|
| Does mental activity increase your symptoms? | YES | NO |
| Does physical activity increase your symptoms? | YES | NO |

v. 2022-04-27

I, ______________________________, declare that the above information is true and accurate to the best of my knowledge.
Print Patient's Name

Signature

Date

Woodbine Chiropractic & Massage Therapy
300-2525 Woodview Drive SW, Calgary, Alberta T2W 4N4

Dr. Irvin Lee-Ying
Dr. Wendy Kwok

T: 403.238.7700 F: 403.238.7808
W: woodbinechiropractic.ca
E: info@woodbinechiropractic.ca

# PLEASE READ CAREFULLY

## A. Clinic Policies

### 1. Privacy and Sharing of Information

I authorize the clinic and its Chiropractors to collect my personal and medical information as documented above. In addition, I authorize the clinic and its Chiropractors to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

### 2. Cancellation Policy

Your appointment time is reserved just for you. A late cancellation or missed visit results in an unexpected vacancy in the Chiropractor's day that could have been filled by another patient. As such, we require 24-hours notice for any cancellations or changes to your appointment. Patients who provide less than 24-hours notice, or miss their appointment, may be charged a cancellation fee.

## B. Insurance

### 1. Benefit Assignment Policy

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.
If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

### 2. Consent to Collect and Exchange Personal Information

**Message to the Plan member, Spouse and/or Dependent regarding Personal Information**

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

## 3. Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize the insurer and / or plan administrator and their service provider(s) to:

- Use my personal information for the above purposes.
- Exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- Exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

## 4. Electronic Transmission Authorization and Consent Form

**Additional Consent Applicable to Plan Members Only**

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

I, ______________________________________________, have read and understand the
Print Patient's Name

policies. I agree to respect and abide by the conditions outlined above.

_________________________________ _________________________________

Signature Date

# LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (Revised Oswestry)

Name: ______________________________________________ Date: ____________________

**PLEASE READ INSTRUCTIONS:**

*This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.*

**SECTION 1 – PAIN INTENSITY**

- ❑ The pain comes and goes and is very mild.
- ❑ The pain is mild and does not vary much.
- ❑ The pain comes and goes and is moderate.
- ❑ The pain is moderate and does not vary much.
- ❑ The pain comes and goes and is severe.
- ❑ The pain is severe and does not vary much.

**SECTION 2 – PERSONAL CARE (washing, dressing, etc.)**

- ❑ I would not have to change my way of washing or dressing in order to avoid pain.
- ❑ I do not normally change my way of washing or dressing even though it causes pain.
- ❑ Washing and dressing increase the pain but I manage not to change my way of doing it.
- ❑ Washing and dressing increase the pain and I find it necessary to change my way of doing it.
- ❑ Because of the pain I am unable to do some washing and dressing without help.
- ❑ Because of the pain I am unable to do any washing and dressing without help.

**SECTION 3 – LIFTING**

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it causes extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table).
- ❑ Pain prevents me from lifting heavy weights, but I can manage light or medium weights if they are conveniently positioned.
- ❑ I can only lift very light weights at the most.

**SECTION 4 – WALKING**

- ❑ I have no pain on walking.
- ❑ I have some pain on walking but it does not increase with distance.
- ❑ I cannot walk for more than one km without increasing pain.
- ❑ I cannot walk for more than ½ km without increasing pain.
- ❑ I cannot walk for more than ¼ km without increasing pain.
- ❑ I cannot walk at all without increasing pain.

**SECTION 5 – SITTING**

- ❑ I can sit in any chair as long as I like.
- ❑ I can only sit in my favourite chair as long as I like.
- ❑ Pain prevents me from sitting for more than 1 hour.
- ❑ Pain prevents me from sitting for more than ½ hour.
- ❑ Pain prevents me from sitting for more than 10 minutes.
- ❑ I avoid sitting because it increases pain straight away.

**SECTION 6 – STANDING**

- ❑ I can stand as long as I want without pain.
- ❑ I have some pain on standing but it does not increase with time.
- ❑ I cannot stand for longer than 1 hour without increasing pain.
- ❑ I cannot stand for longer than ½ hour without increasing pain.
- ❑ I cannot stand for longer than 10 minutes without increasing pain.
- ❑ I avoid standing because it increases the pain straight away.

**SECTION 7 – SLEEPING**

- ❑ I get no pain in bed.
- ❑ I get pain in bed but it does not prevent me from sleeping well.
- ❑ Because of pain my normal night's sleep is reduced by less than ¼.
- ❑ Because of pain my normal night's sleep is reduced by less than ½.
- ❑ Because of pain my normal night's sleep is reduced by less than ¾.
- ❑ Pain prevents me from sleeping at all.

**SECTION 8 – SOCIAL LIFE**

- ❑ My social life is normal and gives me no pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g. dancing, etc.)
- ❑ Pain has restricted my social life and I do not go out very often.
- ❑ Pain has restricted my social life to my home.
- ❑ I have hardly any social life because of the pain.

**SECTION 9 – TRAVELLING**

- ❑ I get no pain whilst travelling.
- ❑ I get some pain whilst travelling but none of my usual forms of travel make it any worse.
- ❑ I get extra pain whilst travelling but it does not compel me to seek alternative forms of travel.
- ❑ I get extra pain whilst travelling which compels me to seek alternative forms of travel.
- ❑ Pain restricts all forms of travel.
- ❑ Pain prevents all forms of travel except that done lying down.

**SECTION 10 – CHANGING DEGREE OF PAIN**

- ❑ My pain is rapidly getting better.
- ❑ My pain fluctuates but overall is definitely getting better.
- ❑ My pain seems to be getting better but improvement is slow at present.
- ❑ My pain is neither getting better nor worse.
- ❑ My pain is gradually worsening.
- ❑ My pain is rapidly worsening.

**PAIN SCALE:** Rate the severity of your pain by checking one box on the following scale.

| No pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Excruciating pain |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

# NECK PAIN AND DISABILITY QUESTIONNAIRE (Vernon-Mior)

Name: ______________________________ Date: ______________

**PLEASE READ INSTRUCTIONS:**

*This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only ONE box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.*

**SECTION 1 – PAIN INTENSITY**

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

**SECTION 2 – PERSONAL CARE (washing, dressing, etc.)**

- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally but it causes extra pain.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed, I wash with difficulty and stay in bed.

**SECTION 3 – LIFTING**

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it gives extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift very light weights.
- ❑ I cannot lift or carry anything at all.

**SECTION 4 – READING**

- ❑ I can read as much as I want to with no pain in my neck.
- ❑ I can read as much as I want to with slight pain in my neck.
- ❑ I can read as much as I want to with moderate pain in my neck.
- ❑ I can’t read as much as I want because of moderate pain in my neck.
- ❑ I can hardly read at all because of severe pain in my neck.
- ❑ I cannot read at all.

**SECTION 5 – HEADACHES**

- ❑ I have no headaches at all.
- ❑ I have slight headaches which come infrequently.
- ❑ I have moderate headaches which come infrequently.
- ❑ I have moderate headaches which come frequently.
- ❑ I have severe headaches which come frequently.
- ❑ I have headaches almost all the time.

**SECTION 6 – CONCENTRATION**

- ❑ I can concentrate fully when I want to with no difficulty.
- ❑ I can concentrate fully when I want to with slight difficulty.
- ❑ I have a fair degree of difficulty in concentrating when I want to.
- ❑ I have a lot of difficulty in concentrating when I want to.
- ❑ I have a great deal of difficulty in concentrating when I want to.
- ❑ I cannot concentrate at all.

**SECTION 7 – WORK**

- ❑ I can do as much work as I want to.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I cannot do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I cannot do any work at all.

**SECTION 8 – DRIVING**

- ❑ I can drive my car without any neck pain.
- ❑ I can drive my car as long as I want with slight pain in my neck.
- ❑ I can drive my car as long as I want with moderate pain in my neck.
- ❑ I cannot drive my car as long as I want because of moderate pain in my neck.
- ❑ I can hardly drive at all because of severe pain in my neck.
- ❑ I cannot drive my car at all.

**SECTION 9 – SLEEPING**

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed (less than 1 hour sleepless).
- ❑ My sleep is mildly disturbed (1-2 hours sleepless).
- ❑ My sleep is moderately disturbed (2-3 hours sleepless).
- ❑ My sleep is greatly disturbed (3-5 hours sleepless).
- ❑ My sleep is completely disturbed (5-7 hours sleepless).

**SECTION 10 – RECREATION**

- ❑ I am able to engage in all my recreation activities with no neck pain at all.
- ❑ I am able to engage in all my recreation activities with some pain in my neck.
- ❑ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ❑ I am able to engage in few of my usual recreation activities because of pain in my neck.
- ❑ I can hardly do any recreation activities because of pain in my neck.
- ❑ I cannot do any recreation activities at all.

**PAIN SCALE:** Rate the severity of your pain by checking one box on the following scale.

| No pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Excruciating pain |
|---|---|---|---|---|---|---|---|---|---|---|---|---|