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# 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

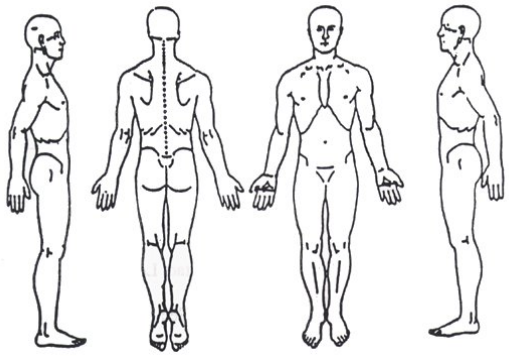
ADDRESS | CITY, PROVINCE | POSTAL CODE

## 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**

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| "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



I, _____, declare that the above information is true and accurate to the best of my knowledge.

Print Patient's Name

Signature _____ Date _____

# F E E  S C H E D U L E

## Chiropractic

The Fee Schedule is based on recommendations from the College of Chiropractors of Alberta and a reflection of the current economic conditions.

| | |
|---|---|
| Initial Examination (1hr) | $140 |
| Chiropractic Treatment | $ 60 |
| Re-Examination (>1year) | $ 90 |
| | |
| Cold Laser Therapy | $ 60 |
| Laser & Adjustment | $ 80 |
| Acupuncture | $ 80 |
| | |
| Normalizer Pillow | $ 90 |
| Custom Orthotic Therapy | $425 |

**The appointment times are booked especially for you.**

**Missed appointments without 24-hours notice will be charged the Clinic Fee for that visit.** We understand that medical emergencies or extenuating circumstances may be beyond your control, however, each situation will be considered carefully.

**Payment is due on day of visit. We accept credit, debit, and cash payment methods.** If applicable, we will direct bill your insurance company and the balance owing is your responsibility. Receipts or Statements of Account can be provided on request.

I give permission to Woodbine Chiropractic & Massage Therapy to share my information to the Insurance provider(s) for the purposes of direct-billing for services rendered.

Thank you for your consideration and understanding.

I, _____, have read and understand the Fee Schedule and Cancellation Policy.
Print Patient's Name
I agree to respect the Chiropractor's time for me and other patients at the clinic.

_____ _____
Patient's 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|