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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 / (PRONOUNS) AGE DOB (DD/MMM/YYYY) 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 PREVIOUS 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

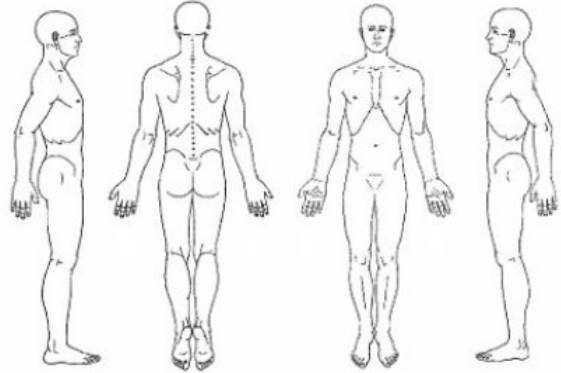
Did the current injury occur as a result of a Motor Vehicle Accident?

YES

NO

8 HEALTH CONCERNS / LIFESTYLE

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



Please list any surgeries, injuries, accidents, and falls that you have had in the past.

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

Please list any allergies or sensitivities:

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:

Frequency:

Smoking | Vaping | Marijuana

Frequency:

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

Print Patient's Name

Signature

Date



FEE SCHEDULE

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 (15-30min)	\$ 65
Re-Examination (>1year)	\$ 95
Cold Laser Therapy	\$ 65
Laser & Adjustment	\$ 85
Acupuncture	\$ 95
Normalizer Pillow	\$ 95
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.

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.

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.

Thank you for your consideration and understanding.

I, _____, have read and understand the Fee Schedule and
Print Patient's Name
Cancellation Policy. 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.

<p>SECTION 1 – PAIN INTENSITY</p> <ul style="list-style-type: none"> <input type="checkbox"/> The pain comes and goes and is very mild. <input type="checkbox"/> The pain is mild and does not vary much. <input type="checkbox"/> The pain comes and goes and is moderate. <input type="checkbox"/> The pain is moderate and does not vary much. <input type="checkbox"/> The pain comes and goes and is severe. <input type="checkbox"/> The pain is severe and does not vary much. <p>SECTION 2 – PERSONAL CARE (washing, dressing, etc.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> I would not have to change my way of washing or dressing in order to avoid pain. <input type="checkbox"/> I do not normally change my way of washing or dressing even though it causes pain. <input type="checkbox"/> Washing and dressing increase the pain but I manage not to change my way of doing it. <input type="checkbox"/> Washing and dressing increase the pain and I find it necessary to change my way of doing it. <input type="checkbox"/> Because of the pain I am unable to do some washing and dressing without help. <input type="checkbox"/> Because of the pain I am unable to do any washing and dressing without help. <p>SECTION 3 – LIFTING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can lift heavy weights without extra pain. <input type="checkbox"/> I can lift heavy weights but it causes extra pain. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g. on a table). <input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light or medium weights if they are conveniently positioned. <input type="checkbox"/> I can only lift very light weights at the most. <p>SECTION 4 – WALKING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I have no pain on walking. <input type="checkbox"/> I have some pain on walking but it does not increase with distance. <input type="checkbox"/> I cannot walk for more than one km without increasing pain. <input type="checkbox"/> I cannot walk for more than ½ km without increasing pain. <input type="checkbox"/> I cannot walk for more than ¼ km without increasing pain. <input type="checkbox"/> I cannot walk at all without increasing pain. <p>SECTION 5 – SITTING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can sit in any chair as long as I like. <input type="checkbox"/> I can only sit in my favourite chair as long as I like. <input type="checkbox"/> Pain prevents me from sitting for more than 1 hour. <input type="checkbox"/> Pain prevents me from sitting for more than ½ hour. <input type="checkbox"/> Pain prevents me from sitting for more than 10 minutes. <input type="checkbox"/> I avoid sitting because it increases pain straight away. 	<p>SECTION 6 – STANDING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can stand as long as I want without pain. <input type="checkbox"/> I have some pain on standing but it does not increase with time. <input type="checkbox"/> I cannot stand for longer than 1 hour without increasing pain. <input type="checkbox"/> I cannot stand for longer than ½ hour without increasing pain. <input type="checkbox"/> I cannot stand for longer than 10 minutes without increasing pain. <input type="checkbox"/> I avoid standing because it increases the pain straight away. <p>SECTION 7 – SLEEPING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I get no pain in bed. <input type="checkbox"/> I get pain in bed but it does not prevent me from sleeping well. <input type="checkbox"/> Because of pain my normal night's sleep is reduced by less than ¼. <input type="checkbox"/> Because of pain my normal night's sleep is reduced by less than ½. <input type="checkbox"/> Because of pain my normal night's sleep is reduced by less than ¾. <input type="checkbox"/> Pain prevents me from sleeping at all. <p>SECTION 8 – SOCIAL LIFE</p> <ul style="list-style-type: none"> <input type="checkbox"/> My social life is normal and gives me no pain. <input type="checkbox"/> My social life is normal but increases the degree of pain. <input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g. dancing, etc.) <input type="checkbox"/> Pain has restricted my social life and I do not go out very often. <input type="checkbox"/> Pain has restricted my social life to my home. <input type="checkbox"/> I have hardly any social life because of the pain. <p>SECTION 9 – TRAVELLING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I get no pain whilst travelling. <input type="checkbox"/> I get some pain whilst travelling but none of my usual forms of travel make it any worse. <input type="checkbox"/> I get extra pain whilst travelling but it does not compel me to seek alternative forms of travel. <input type="checkbox"/> I get extra pain whilst travelling which compels me to seek alternative forms of travel. <input type="checkbox"/> Pain restricts all forms of travel. <input type="checkbox"/> Pain prevents all forms of travel except that done lying down. <p>SECTION 10 – CHANGING DEGREE OF PAIN</p> <ul style="list-style-type: none"> <input type="checkbox"/> My pain is rapidly getting better. <input type="checkbox"/> My pain fluctuates but overall is definitely getting better. <input type="checkbox"/> My pain seems to be getting better but improvement is slow at present. <input type="checkbox"/> My pain is neither getting better nor worse. <input type="checkbox"/> My pain is gradually worsening. <input type="checkbox"/> My pain is rapidly worsening.
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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
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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.

<p>SECTION 1 – PAIN INTENSITY</p> <p><input type="checkbox"/> I have no pain at the moment.</p> <p><input type="checkbox"/> The pain is very mild at the moment.</p> <p><input type="checkbox"/> The pain is moderate at the moment.</p> <p><input type="checkbox"/> The pain is fairly severe at the moment.</p> <p><input type="checkbox"/> The pain is very severe at the moment.</p> <p><input type="checkbox"/> The pain is the worst imaginable at the moment.</p> <p>SECTION 2 – PERSONAL CARE (washing, dressing, etc.)</p> <p><input type="checkbox"/> I can look after myself normally without causing extra pain.</p> <p><input type="checkbox"/> I can look after myself normally but it causes extra pain.</p> <p><input type="checkbox"/> It is painful to look after myself and I am slow and careful.</p> <p><input type="checkbox"/> I need some help but manage most of my personal care.</p> <p><input type="checkbox"/> I need help every day in most aspects of self-care.</p> <p><input type="checkbox"/> I do not get dressed, I wash with difficulty and stay in bed.</p> <p>SECTION 3 – LIFTING</p> <p><input type="checkbox"/> I can lift heavy weights without extra pain.</p> <p><input type="checkbox"/> I can lift heavy weights but it gives extra pain.</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.</p> <p><input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.</p> <p><input type="checkbox"/> I can lift very light weights.</p> <p><input type="checkbox"/> I cannot lift or carry anything at all.</p> <p>SECTION 4 – READING</p> <p><input type="checkbox"/> I can read as much as I want to with no pain in my neck.</p> <p><input type="checkbox"/> I can read as much as I want to with slight pain in my neck.</p> <p><input type="checkbox"/> I can read as much as I want to with moderate pain in my neck.</p> <p><input type="checkbox"/> I can't read as much as I want because of moderate pain in my neck.</p> <p><input type="checkbox"/> I can hardly read at all because of severe pain in my neck.</p> <p><input type="checkbox"/> I cannot read at all.</p> <p>SECTION 5 – HEADACHES</p> <p><input type="checkbox"/> I have no headaches at all.</p> <p><input type="checkbox"/> I have slight headaches which come infrequently.</p> <p><input type="checkbox"/> I have moderate headaches which come infrequently.</p> <p><input type="checkbox"/> I have moderate headaches which come frequently.</p> <p><input type="checkbox"/> I have severe headaches which come frequently.</p> <p><input type="checkbox"/> I have headaches almost all the time.</p>	<p>SECTION 6 – CONCENTRATION</p> <p><input type="checkbox"/> I can concentrate fully when I want to with no difficulty.</p> <p><input type="checkbox"/> I can concentrate fully when I want to with slight difficulty.</p> <p><input type="checkbox"/> I have a fair degree of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I have a lot of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I have a great deal of difficulty in concentrating when I want to.</p> <p><input type="checkbox"/> I cannot concentrate at all.</p> <p>SECTION 7 – WORK</p> <p><input type="checkbox"/> I can do as much work as I want to.</p> <p><input type="checkbox"/> I can only do my usual work, but no more.</p> <p><input type="checkbox"/> I can do most of my usual work, but no more.</p> <p><input type="checkbox"/> I cannot do my usual work.</p> <p><input type="checkbox"/> I can hardly do any work at all.</p> <p><input type="checkbox"/> I cannot do any work at all.</p> <p>SECTION 8 – DRIVING</p> <p><input type="checkbox"/> I can drive my car without any neck pain.</p> <p><input type="checkbox"/> I can drive my car as long as I want with slight pain in my neck.</p> <p><input type="checkbox"/> I can drive my car as long as I want with moderate pain in my neck.</p> <p><input type="checkbox"/> I cannot drive my car as long as I want because of moderate pain in my neck.</p> <p><input type="checkbox"/> I can hardly drive at all because of severe pain in my neck.</p> <p><input type="checkbox"/> I cannot drive my car at all.</p> <p>SECTION 9 – SLEEPING</p> <p><input type="checkbox"/> I have no trouble sleeping.</p> <p><input type="checkbox"/> My sleep is slightly disturbed (less than 1 hour sleepless).</p> <p><input type="checkbox"/> My sleep is mildly disturbed (1-2 hours sleepless).</p> <p><input type="checkbox"/> My sleep is moderately disturbed (2-3 hours sleepless).</p> <p><input type="checkbox"/> My sleep is greatly disturbed (3-5 hours sleepless).</p> <p><input type="checkbox"/> My sleep is completely disturbed (5-7 hours sleepless).</p> <p>SECTION 10 – RECREATION</p> <p><input type="checkbox"/> I am able to engage in all my recreation activities with no neck pain at all.</p> <p><input type="checkbox"/> I am able to engage in all my recreation activities with some pain in my neck.</p> <p><input type="checkbox"/> I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.</p> <p><input type="checkbox"/> I am able to engage in few of my usual recreation activities because of pain in my neck.</p> <p><input type="checkbox"/> I can hardly do any recreation activities because of pain in my neck.</p> <p><input type="checkbox"/> I cannot do any recreation activities at all.</p>
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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
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