ATHLETIC THERAPY
PATIENT HISTORY
AGES 13 – ADULT

Care Chiropractic Health & Rehab

Patient Information

Patient's Legal Name: _____ Preferred Name: _____ Date: _____

Address: _____ City: _____ Postal Code:_____

Telephone Home #: _____ Work #: _____ Cell #: _____

Cell Provider (optional): _____ Email (optional):_____

**Your cell and email will not be shared with third parties & is used for appointment reminders. I understand that I can opt out at any time by informing CARE that I no longer wish to receive appointment reminders.*

Birth Date: D/ _____ M/ _____ Y/ _____ Age: _____ ❑ M ❑ F Married ___ Single ___ # Children? _____

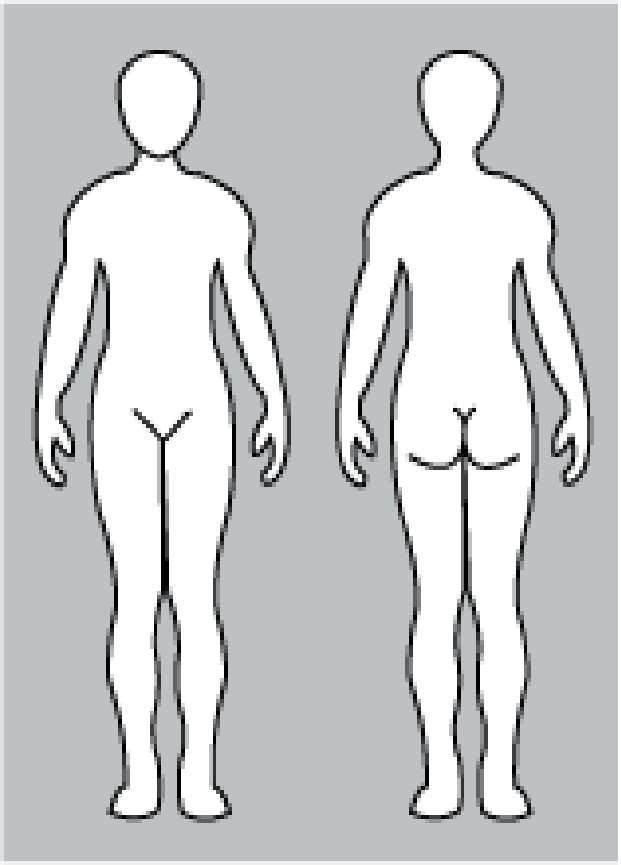
Occupation _____

In case of emergency, contact: _____ Phone: _____

Whom may we thank for referring you to our office? _____ Is this a W.C.B? ❑ Yes ❑ No

Current Condition

1. What is the purpose of your appointment? ❑ Wellness ❑ Automobile Accident ❑ Other: _____



2. Please indicate by marking areas on the chart using the following symbols:

oooo	Pins and Needles
////	Stabbing
xxxx	Burning
+++	Aching
= = =	Numbness
▲▲▲	Stiffness

Using the scale below, place a vertical line (|) relative to your current pain or discomfort

No pain — Worst possible pain

3. Is your condition interfering with your: ❑ Quality of Life ❑ Work ❑ Sleep ❑ Other: _____

4. Have you had this problem before? ❑ Yes ❑ No: _____

5. Other Doctors seen for this condition (please circle):

MD / Neurologist / Orthopedic Surgeon / Chiropractor / Other: _____

Doctor's Name: _____ Diagnosis: _____ Were X-Rays Taken? ❑ Yes ❑ No Treatment: _____

Physiotherapy/Muscle Therapy? ❑ Yes ❑ No Results, Did it help? ❑ Yes ❑ No

Relevant History

6. Date of last physical exam _____ Purpose _____

Female: Pregnant? ❑ Yes ❑ No ❑ Unsure Due Date: _____

7. What over the counter or prescription drugs are you taking? _____

8. Have you ever:	No	Yes	Briefly Explain:
Broken bones?	❑	❑	_____
Been hospitalized?	❑	❑	_____
Been in an auto accident?	❑	❑	_____
Had sprains/strains?	❑	❑	_____
Been struck unconscious?	❑	❑	_____
Had surgery?	❑	❑	_____

9. Have you ever been to an Athletic Therapist? ❑ Yes ❑ No
Reason? _____Last time you saw him/her? _____

10. Are you currently suffering from any of the following (please circle):

Allergy/Hay Fever	Low Back Pain	Tuberculosis	Itching
Dizziness	Neck Pain/Stiffness	Pleurisy	Psoriasis/Eczema
Fatigue	Poor Posture	Bruise Easily	Bedwetting
Headache/Migraines	Sciatica	Nosebleeds	Frequent Urination
Loss of Sleep	Spinal Curvatures	Sinus Infection	Kidney Infection/Stone
Ulcers	Swollen Joints/Ankles	High/Low Blood Press.	Prostate Trouble
Nervousness/Depression	Colon Trouble	Heart Disease	Heavy Menstrual Flow
Numbness	Menstrual Cramps	Pain over heart	Irregular Cycle
Arthritis	Difficult Digestion	Poor Circulation	Hot flashes
Bursitis	Hemorrhoids	Rapid/Slow Heartbeat	Lumps in Breast
Foot Trouble	Nausea	Anemia	Cancer
Asthma	Stroke	Chest Pain	Polio
Colds	Enlarged Thyroid	Difficulty Breathing	AIDS/HIV Positive
Deafness	Eye Pain/Bad Vision	Alcoholism	Chronic Fatigue Syndrome
Ear Noises	Hypoglycemia	Diabetes	Fibromyalgia
Other: _____			Venereal Disease

Events and Habits

11. Do you have any family history of illness? _____

12. Circle your level of stress at: **Home:** High / Medium / Low **Work/School:** High / Medium / Low

13. Are you wearing: ❑ Heel Lifts ❑ Prescribed Orthotics ❑ Arch Supports

14. Are you taking nutritional supplements? ❑ No ❑ Yes: _____

15. Describe your habits:

	Heavy	Moderate	Light	None
Alcohol	❑	❑	❑	❑
Coffee	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Sleep	❑	❑	❑	❑
Soft Drinks	❑	❑	❑	❑
Water	❑	❑	❑	❑
Medical Cannabis	❑	❑	❑	❑
Recreational Drugs	❑	❑	❑	❑

PAYMENT IS EXPECTED AT THE TIME OF VISIT!

Name of person responsible for payment_____
I 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 my care, any fees for professional services rendered will be immediately due and payable.

I acknowledge that the Athletic Therapist is not a physician & does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that Athletic Therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailment that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge & understand that the Athletic Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Athletic Therapist & disclosed all medical conditions affecting me. It is my responsibility to keep the Athletic Therapist updated on my medical history. The information I have provided is true & complete to the best of my knowledge.

Consent to the Collection, Use and Disclosure of Personal Health Information: Maintaining the protection of your personal health information is required by provincial and federal law. This information will be securely maintained in charts or electronically for a minimum of ten years past the last date of treatment. To access this information, the Clinic must receive your written consent to release this information to a designated individual or organization. You also understand that this information will be accessible to and shared amongst each of the health service providers within the clinic for the purposes of providing integrated, patient centered health services for:

*Chiropractic/Massage Therapy/Acupuncture/Athletic Therapy or other clinical services
*To obtain payment from a third party insurance company for treatments provided, if applicable.

I understand that I can withdraw my consent to collect, use and disclose my personal health information by providing written notice to the treating practitioner

Patient's Signature _____ Date: _____

Guardian/Parent's Signature _____Date: _____