ORCHARD
CHIROPRACTIC & PHYSIOTHERAPY

212- 1980 Cooper Road
Kelowna BC
V1Y 8K5
250-717-7732
orchardchiropractic.ca

Name _____

Birthdate _____**(month / day / year)**

Address _____

_____

Phone _____

☐ **Bell** ☐ **Telus** ☐ **Rogers** ☐ **Other:** _____

Email _____

Appointment reminder by: ☐ **Text** ☐ **Email** ☐ **Phone**

Occupation _____

How did you hear about our clinic? _____

Emergency Contact _____

Phone_____

Care Card # _____

Extended Medical Insurer_____

Member ID # _____

Policy #: _____

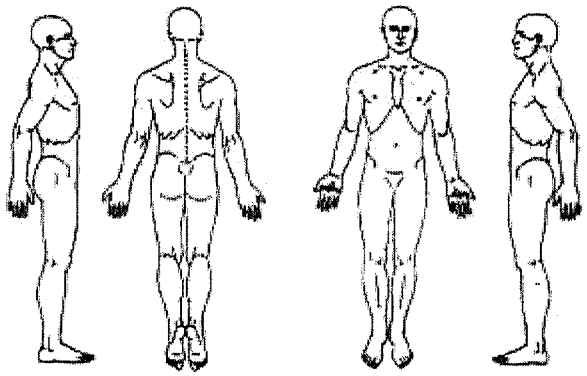
*OCP can submit to your extended medical insurer on your behalf, but we **DO NOT** direct bill.

ICBC or WCB? ☐ **No** ☐ **Yes Claim#**_____

(if active claim, please inform practitioner as you will need to fill out the related Claim Form)

☆CURRENT CONDITION☆

Please indicate on the picture below and describe your current condition & symptoms:



_____

_____

How long have you had this condition/symptom?

_____

Have you had this condition before? ☐ YES ☐ NO

When? _____

What makes it **better** (positions/activities/movements)?

_____

What makes it **worse**(positions/activities/movements)?

_____

What % of each day does it **bother you**? (Circle one)

0% 25%(Intermittent) 50%(Occasional) 75%(Frequent) 100%(Constant)

Does this **affect you** at:

☐ Work ☐ Play/Activities/Exercise ☐ Sleep ☐ Romance/Love life

Please circle the number that most accurately represents your average pain level:

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable)

GOALS FOR CARE: Check all that apply

- ☐ RELIEF: I want to feel better for the least amount of my time and money.
- ☐ CORRECTION: I want a comprehensive treatment plan to help fully recover and obtain optimal function/stabilization.
- ☐ MAINTENANCE/PREVENTION: I want to preserve my progress, prevent future injury and improve physical longevity.
- ☐ PERFORMANCE: I want sports/activity specific care to help me perform at my best.

PERSONAL HEALTH HISTORY - The following lists a variety of conditions that patients may experience. Please read through the list and check the box next to each condition that applies to you.

GENERAL CURRENT CONDITIONS

- ❑ **Recent accident** such as a fall, whiplash, or blow to the head
- ❑ Spinal/back/neck problems
- ❑ Muscle spasms
- ❑ Restricted movement
- ❑ Numbness or tingling of hands or feet or radiating pain
- ❑ Headaches or Migraines
- ❑ Sinus problems
- ❑ Nausea
- ❑ Depression
- ❑ Anxiety or difficulty with stress
- ❑ Dizziness or vertigo
- ❑ Vision problem
- ❑ Hearing problem
- ❑ Sleeping trouble
- ❑ Asthma or breathing problem
- ❑ Digestive trouble
- ❑ Heartburn/Acid Reflux
- ❑ Menstrual problems
- ❑ Jaw or mouth problem
- ❑ Arm, shoulder, elbow or hand problem
- ❑ Leg, hip, knee or foot problem
- ❑ Concussion

Do you currently wear orthotics?
☐Yes ☐No

DIAGNOSED CONDITIONS

- ❑ Born with bone or joint disorder
- ❑ Osteoporosis
- ❑ Degenerative arthritis/Osteoarthritis
- ❑ Rheumatoid arthritis
- ❑ Compression fracture
- ❑ Heart attack or heart disorder
- ❑ History of stroke or aneurysm
- ❑ Cancer
- ❑ Diabetes
- ❑ Gout
- ❑ Lupus
- ❑ Ankylosing spondylitis
- ❑ Immune suppression treatment or disorder from chemotherapy, organ transplant, drug, etc.
- ❑ 3 or more months of steroid medications or intravenous drugs (past or present)
- ❑ Tuberculosis
- ❑ Hepatitis B or HIV infection
- ❑ Multiple sclerosis
- ❑ Thyroid or hormone disorder
- ❑ High blood pressure
- ❑ Convulsions/epilepsy
- ❑ OTHER:_____

SPECIFIC PAIN IN THE BODY

- ❑ Difficulty swallowing because of neck pain
- ❑ Pain or electric shocks in arms or legs when moving neck
- ❑ Leg pain worse with exercise
- ❑ Numbness of inner thighs
- ❑ Back pain with urinary problems
- ❑ Severe pain that interrupts sleep
- ❑ Constant pain that doesn't improve by changing positions or by lying down

SPECIFIC CURRENT CONDITIONS

- ❑ Poor balance
- ❑ Loss of bowel or bladder control
- ❑ Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- ❑ Memory loss after injury
- ❑ Recent, unexplained weight loss
- ❑ Recent progressive muscle weakness or shaking
- ❑ Recent or current fever over 102°

Describe any **surgeries** / hospitalizations / motor vehicle accidents / sporting accidents / personal/work accidents / fractures / dislocations / & / or illnesses you've had and the **dates**:

Incident	Date

Please list any Medications and/or supplements you presently take AND what condition you are taking them for:

Medication	Condition

Known Allergies (including medications, foods, seasonal, oils and lotions, etc.)

Your **Medical Practitioner's** Name: _____

Date last seen:_____ Recent medical testing: Xrays___ Blood test ____ Other____

YOUR LIFESTYLE

Height _____ **Weight** _____
Has your **weight** changed recently? ☐ Gained ☐ Lost ☐ No change
How many **hours of sleep**_____
Sleep position: ☐ Side ☐ Front ☐ Back
Quality of sleep: ☐ Poor ☐ Moderate ☐ Excellent
Do you drink **Alcohol**?_____drinks/day
Grind your teeth/clench? ☐ No ☐ Yes
How many **hours do you sit**? _____/day

Diet: ☐ Poor ☐ Moderate ☐ Excellent
Do you **Smoke**: ☐ No ☐ Yes
Exercise: ☐ No ☐ Yes, _____/week
☐ Gym/Cardio ☐ Weights ☐ Core
☐ Yoga ☐ Pilates ☐ Bootcamp
☐ Crossfit ☐ Biking ☐ Running
☐ Swimming ☐ Other:_____

For Women: Are you pregnant? ☐ Yes ☐ No Date of Last Period:_____

TREATMENT HISTORY:

	Name/Location	Date of last visit	Result	Comments
Massage Therapy			Excellent Good Fair Poor	
Chiropractor			Excellent Good Fair Poor	
Physiotherapy			Excellent Good Fair Poor	
Naturopath			Excellent Good Fair Poor	
Acupuncture			Excellent Good Fair Poor	
Other (specify)			Excellent Good Fair Poor	

Please initial each statement:

___ Your appointment time has been reserved for you. In courtesy of your practitioner & fellow patients, we ask that you provide us with **24 hours notice of cancellation**, or a cancellation fee will be charged for the full amount of the treatment. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

___ I authorize the clinic and its associated Practitioners to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and it's associated practitioners to communicate with my referring MD 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.

___ I understand that Orchard Chiropractic & Physiotherapy uses electronic means for charting, using a secured database, and that all practitioners to which I am under the care of have access to this health record.

___ It is my choice to receive treatment. I agree to communicate with my practitioner any time I feel my well-being is being compromised, or if I am uncomfortable with any treatment modalities.

___ I have stated all medical conditions that I am aware of on the health history form, and will update my practitioner of any changes in my health status.

___ I understand that Registered Massage Therapists are provincially licensed and trained in soft tissue work. They do not diagnose illness, disease or physical/mental disorders: nor do they prescribe medical treatment, pharmaceuticals and nutritional therapies, or perform grade 5 spinal thrust manipulations (chiropractic adjustments). I acknowledge that massage is not a substitute for a medical examination or diagnosis.

___ I understand that individual practitioners at Orchard Chiropractic & Physiotherapy may obtain additional informed consent, depending on treatment modalities applied.

Signature: **Date:**