1977 – 2019 Providing Over 40 Years of Exceptional Patient Care

High Point Wellness Centre

HPWC Clinical Team

- □ Dr. Chapin, DC
- □ Dr. Fligg, DC
- □ Dr. Danson, DC
- □ Dr. Weinberg, DC
- □ Dr. Neale, DC
- □ Dr. Sawa, DC
- □ Dr. Welsh, DC
- □ D. Armena, P.T
- □ Z. Herskovits, P.T.
- □ E. Tanubrata, P.T.
- □ Dr. K. Harpell, ND
- □ Dr. N. Litvak, ND
- □ N. Qureshi, RD
- □ M. Parsons, RMT
- □ S. Forrester, RMT
- □ M. Bogovic, RMT
- □ G. Padrique, RMT
- □ A. Jurkiewicz, RMT
- □ M. Malloy, RMT

New Patient Confidential Health Record

Date: _____ (yyyy / mmm / dd) _____

Last name: _____ **First Name** _____

Address: _____

Suite/Apt #: _____ **City:** _____ **Postal Code** _____

Home Phone #:_____ **Work Phone #:** _____ **Cell Phone #** _____

Email: _____

Date of Birth: _____ /_____ /____ **Gender: Male / Female** **Referred by:**_____
yyyy / mmm / dd

Employer: _____ **Occupation:** _____

Emergency Contact Name:_____ **Tel.** _____

Relationship:_____

Areas of Concern

Some patients come to us in pain, others to improve their performance. How can we help you?

- ☐ I have had a recent injury. I am in pain and in need of help
- ☐ I am suffering from an old injury
- ☐ I am not sure what I have done but my pain is getting worse
- ☐ My body no longer moves like it used to
- ☐ I am not in pain. I wish to improve my physical abilities
- ☐ I am interested in a wellness check-up
- ☐ I am interested in improving my nutritional health
- ☐ I am interested in discussing my overall health with a Naturopathic Doctor or Dietitian

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Please list/describe the location of your symptoms in order of severity:

1) _____
2) _____
3) _____
4) _____

How and when did your condition begin?

If you are experiencing pain, please rate your current pain level on this 10 point scale 10 = severe pain (worst of your life), 0 = no pain

0 1 2 3 4 5 6 7 8 9 10

How would you describe your symptoms?

- □ sharp pain
- □ dull pain
- □ numbness/tingling
- □ weakness
- □ shooting pain
- □ achiness
- □ stiffness
- □ pressure/throbbing
- □ loss of motion or function
- □ aggravated with movement
- □ improves with movement
- □ other _____

I have moments in my day without pain. Yes or No ?

My condition interferes with my day-to-day activities:

- □ No, not at all
- □ Somewhat
- □ Moderately
- □ Yes, considerably

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What aggravates your condition?

What provides you with relief?

Who else have you seen for your condition?

□ Family doctor
□ Orthopedic specialist
□ Neurologist
□ Other _____
□ Rheumatologist
□ Sports Medicine MD
□ Chiropractor
□ Physiotherapist
□ Massage Therapist
□ Naturopath

Are you currently taking any medications? If so, please list:

-
-
-
-
-

How would you rate your overall health? Excellent / Good /Declining / Poor

Understanding your family medical history will help us support your health. Do any of your immediate family members suffer from:

□ Arthritis
□ Heart Disease
□ Colon Cancer
□ Lung Cancer
□ Prostate Cancer
□ Breast Cancer
□ Other Cancer
□ Diabetes
□ Stroke
□ Osteoporosis
□ Mental illness
□ Autoimmune disorder

Have you been diagnosed with any of the following (currently or in the past?)

□ Anemia
□ Arthritis/joint disease
□ Asthma
□ Bleeding disorders
□ Bloating
□ COPD/Lung disease
□ Constipation
□ CVA/Stroke
□ Dementia
□ DVT/Blood clot
□ Frequent indigestion
□ Headaches
□ Hepatitis
□ Hiatal Hernia
□ High Blood Pressure
□ High Cholesterol
□ HIV
□ Infection
□ Kidney Disease
□ Liver Disease
□ Skin Disorders
□ Heart Disease
□ Sleep Problems
□ Thyroid disease
□ Stomach upset
□ Psychiatric disorders

Tell us about your lifestyle. Do you…

□ Live an active lifestyle
□ Live a sedentary lifestyle
□ Smoke. If so, how many cigarettes per day _____
□ Drink alcohol. If so, how many drinks per day _____ or per week _____
□ Exercise daily
□ Exercise weekly
□ Get enough sleep
□ Do you wake feeling rested
□ Do you eat a well-balanced diet

What are your health goals?

1. _____
2. _____
3. _____
4. _____
5. _____

Do you have extended health care coverage?

Chiropractic: □ Yes □ No Amount: _____ Acupuncture: □ Yes □ No Amount: _____
Naturopathic: □ Yes □ No Amount: _____ RMT: □ Yes □ No Amount: _____
Physiotherapy: □ Yes □ No Amount: _____ Dietitian: □ Yes □ No Amount: _____

Accuracy of Information

□ I certify that the above medical information is correct to my knowledge.

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals 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.

□ I Agree

Cancellation Policy
Your appointment time is reserved for you. We respectfully request 24 hours' notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours' notice, or miss their appointment, will be charged a cancellation fee.

□ I am aware of the Cancellation Policy.

Please read the following statements: then check off each box and sign below:

□ Chiropractic treatment may be covered under extended health insurance at work, and or no fault insurance (motor vehicle accident), or WSIB (injured at work), however; in the event that the third party billing does not cover my treatment fees I hereby confirm that I am responsible for any outstanding balances.

□ I have answered all questions and filled in areas that have requested information. The information supplied by me in this questionnaire is accurate and complete. I understand that the withholding of health care information could jeopardize my receiving safe and effective treatment.

□ The High Point Wellness Centre (HPWC) Health Care Providers (HCP) work together as a team, and therefore HCPs often collaborate with each other regarding their patients' diagnosis and care. I hereby consent to my High Point Wellness Centre Health Care Provider collaborating with my case.

□ In the event I am not able to answer the phone when called by the staff of HPWC I hereby authorize the staff to leave a message for me regarding the details of my appointment at the phone numbers provided.

□ I hereby give my consent for High Point Wellness Centre (HPWC) to either obtain or release medical information as deemed necessary, in accordance with privacy policies.

□ As a massage, naturopath, physiotherapy, or nutritional/fitness patient, I understand that if I do not give at least 24 hours notice to cancel an appointment I will be required to pay the full fee for the missed appointment.

□ I hereby consent to my being examined by: _____

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____