□ Dr. Chapin, DC
□ Dr. Fligg, DC
□ Dr. Weinberg, DC
□ Dr. Danson, DC
□ Dr. Neale, DC
□ Dr. Sawa, DC
□ Dr. Welsh, DC
□ Z. Herskovits, P.T.
□ D. Armena, P.T.
□ E. Tanubrata, P.T.

High Point Wellness Centre

1977 – 2019 Providing Over 40 Years of Exceptional Patient Care

□ N. Qureshi, RD
□ Dr. K. Harpell, ND
□ Dr. N. Litvak, ND
□ G. Padrique, RMT
□ A. Jurkiewicz, RMT
□ S. Forrester, RMT
□ M. Bogovic, RMT
□ M. Malloy, RMT
□ M. Parsons, RMT

Date: _____ **Update Patient Information**

Last name: _____, First: _____

Date of last treatment _____/_____/_____ DOB ____/ ____/ ____
month day yr

Home Phone#_____ Work#_____ Cell#_____

Changes in Personal Information

Address: _____ City:_____

Postal Code. _____ Email: _____

Employer: _____/Occupation: _____

Emergency Contact Name:_____ Tel. _____

Relationship: _____

Extended health care coverage for: Chiropractic: Yes___ ; No ___ Amount:_____

Acupuncture Yes___ ; No ___ Amount _____

Dr.'s Comments

Reason For Appointment: □ Recurrence of previous condition
□ New Condition

When did your aggravation/condition begin? _____

Is this condition related to: □ Occupation □ Car Accident □ Home Injury
□ Fall □ Sports Injury □ Other

Have you seen any other Health Professional for this condition? No □: Yes □

Type _____ Results: _____

Are you taking any medication for this condition? No □ Yes □ _____

Is your pain worse in the… Morning □ Mid-day □ Evening □ All Day Long □

Rate your pain on the following scale (circle)… 0 1 2 3 4 5 6 7 8 9 10
mild…>…moderate……>...severe

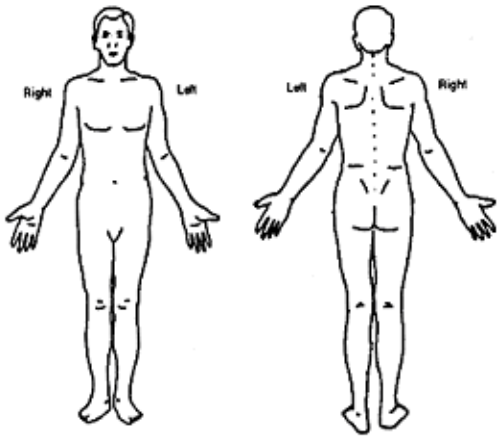
What aggravates your pain? _____

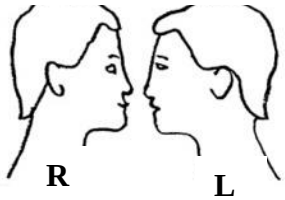
What gives you relief? _____

Have you had X-Rays/CT, MRI, bone density taken? **No** □ **Yes** □ Date:

Location: _____

Mark on the chart and outline on the diagrams the area of discomfort.





LOCATION & SEVERITY OF PROBLEM

Symptom	L	R	Mild	Moderate	Severe
Headache					
Neck					
Shoulder					
Arm					
Elbow					
Wrist					
Hand					
Upper Back					
Chest (Ribs)					
Low Back					
Hip					
Thigh					
Knee					
Lower Leg					
Ankle					
Foot					
Other					
PLEASE DESCRIBE YOUR PAIN					
Stiffness					
Aching					
Burning					
Throbbing					
Sharp					
Stabbing					
Numbness					
Tingling					

Dr.'s Comments/Examination

Diagnosis/Clinical Impression

5110 Creekbank Road, Suite 700, Mississauga, ON, L4W 0A1 Tel: (905) 624.0233 Fax: (905) 624.0881

Changes in Health History

Date of last physical examination: _____

Have you had any hospitalizations □ No □ Yes _____

Check any of the following diseases/infections you have had in the past year:

□ Anemia	□ Arthritis	□ Cancer	□ Chicken pox
□ Diabetes I	□ Diabetes II	□ Eczema	□ Epilepsy
□ Heart Disease	□ Influenza	□ Measles	□ Mumps
□ Pleurisy	□ Pneumonia	□ Polio	□ Rheumatic Fever
□ Small Pox	□ Stroke	□ Thyroid	□ Tuberculosis

Check any of the following you have had within the past year:

General
- □ fatigue
- □ allergies
- □ trouble sleeping
- □ fever
- □ diarrhea

Eyes, Ears, Nose, Throat
- □ vision impairment
- □ dental problems
- □ sore throat
- □ ear ache
- □ ringing in ear
- □ hearing difficulty

Male/Female
- □ menstrual cramps
- □ breast pain/lumps
- □ menstrual irregularity
- □ prostate enlargement

Gastro-Intestinal
- □ poor/excessive appetite
- □ excessive thirst
- □ frequent nausea
- □ vomiting
- □ irregular heart beat
- □ constipation
- □ hemorrhoids
- □ liver disorders
- □ gall bladder disorders
- □ abdominal cramps
- □ gas/bloating after meals
- □ heartburn
- □ black/bloody stool
- □ colitis
- □ weight trouble

Cardiovascular
- □ chest pain
- □ short breath
- □ high blood pressure
- □ low blood pressure

- □ lung disorders
- □ chest congestion
- □ blackouts/fainting
- □ varicose veins
- □ stroke
- □ dizziness

Genito-Urination
- □ bladder dysfunction
- □ urination problems
- □ dis-coloured urine

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

□ **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:** _____