

BACK ON TRACK PHYSIOTHERAPY
CHIROPRACTOR HEALTH HISTORY QUESTIONNAIRE

DATE OF ASSESSMENT: _____

NAME: _____ DOB: _____

HOW & WHEN DID THIS START? _____

HAS THIS HAPPENED BEFORE? _____

IS THE PAIN LOCAL TO THE AREA OR DOES IT TRAVEL? _____

PLEASE IDENTIFY THE SEVERITY OF THE PAIN? NO PAIN 0 1 2 3 4 5 6 7 8 9 10 EXCRUCIATING PAIN

DESCRIBE THE PAIN: (sharp, dull, aching, burning, other)

WHAT AGGRAVATES YOUR COMPLAINT? _____

WHAT RELIEVES YOUR COMPLAINT? _____

HAVE YOU RECEIVED ANY CHIROPRACTIC/PHYSIOTHERAPY/MASSAGE THERAPY TREATMENTS FOR THIS COMPLAINT? _____

HAVE YOU RECEIVED ANY MEDICAL TREATMENT FOR THIS COMPLAINT? _____

HAVE YOU HAD ANY PREVIOUS TRAUMA OR ACCIDENTS? _____

ANY UNEXPLAINED WEIGHT LOSS? **YES / NO**

DO YOU HAVE A FAMILY HISTORY OF:

BLADDER / BOWEL PROBLEMS? **YES / NO**

HEART DISEASE _____ CANCER _____

FEVER OR NIGHT SWEATS? **YES / NO**

ARTHRITIS _____ DIABETES _____

CAN YOU SLEEP THROUGH THE NIGHT? **YES/NO**

OSTEOPOROSIS _____ OTHER _____

ARE YOU ON ANY MEDICATION? _____

DO YOU HAVE ANY ALLERGIES? _____

ANY PREVIOUS SURGERIES? _____

HOW MANY HOURS OF PHYSICAL ACTIVITY DO YOU PERFORM PER WEEK? _____

IS THIS CONDITION PREVENTING YOU FROM DOING ANYTHING? _____

BACK ON TRACK PHYSIOTHERAPY
CHIROPRACTOR HEALTH HISTORY QUESTIONNAIRE

THE INFORMATION RECEIVED IS CONFIDENTIAL AND USED FOR THE PURPOSE OF ENHANCING YOUR CARE.

NAME: _____ TODAY'S DATE: _____

DOB: _____ HOME PHONE: _____

ADDRESS: _____ CELL PHONE: _____

EMAIL: _____

MARITAL STATUS: (CIRCLE ONE) SINGLE MARRIED COMMON LAW DIVORCED WIDOWED

EMERGENCY CONTACT: _____ PHONE: _____

PHYSICIAN'S NAME: _____ PHONE: _____

HOW DID YOU HEAR ABOUT US? _____

IS THIS A RESULT OF A MOTOR VEHICLE ACCIDENT? YES / NO

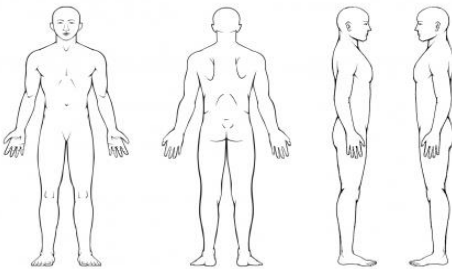
IS THIS A RESULT OF A WORK PLACE INJURY? YES / NO

CLAIM # _____

CLAIM# _____

DATE OF INJURY: _____ INSURANCE CONTACT: _____

PRIMARY COMPLAINT: _____



DO YOU SMOKE? YES / NO

PER WEEK: 1-10 / 10-50 / 50 +

DO YOU DRINK ALCOHOL? YES / NO

PER WEEK: 0-7 / 7-14 / 14+

OCCUPATION: _____

PLEASE CIRCLE ALL AREAS OF COMPLAINT ABOVE

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU.

- | | | | | |
|---------------------------|------------------------|----------------------|-----------------------------|---------------------|
| ____ HEADACHES | ____ FLUSHED FACE | ____ BACK PAIN | ____ NECK PAIN | ____ STIFF NECK |
| ____ DIZZINESS | ____ NUMBNESS | ____ IRRITABILITY | ____ FATIGUE | ____ PINS & NEEDLES |
| ____ COLD HANDS/FEET | ____ DEPRESSION | ____ RINGING IN EARS | ____ LOSS OF BALANCE | ____ ANXIETY |
| ____ SENSITIVITY TO LIGHT | ____ SLEEPING PROBLEMS | ____ MEMORY LOSS | ____ LOSS OF SMELL OR TASTE | ____ ACID REFLUX |
| ____ NAUSEA / VOMITING | ____ DIARRHEA | ____ CONSTIPATION | ____ SHORTNESS OF BREATH | ____ CHEST PAIN |

BACK ON TRACK PHYSIOTHERAPY
CONFIDENTIAL CONSENT, AUTHORIZATION & DIRECTION TO DISCLOSE PERSONAL
INFORMATION

I, _____
(Print Full Name)

Of _____
(Print Full Address)

Hereby consent to the sharing and / or exchange of written and/or verbal information between Novo Healthnet Limited and:

(Print full names and institutions of affiliation)

In respect of

(Print name of the client)

(Date of birth)

Information to be released related to the above-named injury or illness and pertains to the development of treatment and nutritional plans.

I understand that this consent is subject to revocation at any time, except for such action that has already been taken.

A photocopy of this authorization shall have the same validity as the original.

Dated the _____ day of _____, 20____

(Witness)

(Signature)



Cancellation Policy

DATE: _____

Name: _____ DOB: _____

DOL: _____ Claim #: _____

We understand that unplanned issues may come up and you will need to cancel an appointment. If this happens, we respectfully ask that you notify us at least 24 hours prior to your appointment time.

Our therapists want to be available to meet your needs as well as the needs for all of our patients. When a patient does not show up for a scheduled appointment, another patient loses the opportunity to be seen.

If we are not provided with the appropriate notice, you will be responsible for a Missed Treatment charge of \$50.00. For any Missed Massage Treatment, you will be charged in accordance with the RMTAO as follows: 2nd missed massage – 50% of the massage fee / 3rd missed massage – 100 % of the massage fee.

This charge will not be billed to any third-party payors, you will be billed, and it must be paid by you for you to continue to be treated under your claim. Under certain circumstances management may waive this fee.

By signing below, you understand and agree to the cancelation and payment policy.

Patient's Name

Witness Name

Patient's Signature

Witness Signature