Unionville Health Centre
2 Millstone Court, Unionville, ON L3R 7M1 Tel: 905-475-8386

Thank you for coming to our office. We will try to make your experience as pleasant as possible in a warm and friendly environment.

What can I expect? You will be meeting with Fiona Chan on your first visit. The doctor will be looking at your spine and nervous system to determine the cause of your condition. Please complete the questions below to assist the doctor in determining your condition. After you complete the forms, you will review with the doctor your past and present health history. A physical examination will be performed which will include things like checking your posture, spinal mobility, range of motion of joints and muscle tension will be performed. This will provide us with the information we need to determine the best care we can provide for you.

COMPREHENSIVE/CONFIDENTIAL ASSESSMENT QUESTIONNAIRE

Please complete ALL questions carefully.

Today's Date: D_____M_____Y_____

PATIENT INFORMATION:

Last Name: _____ First Name: _____

Address: _____ City: _____ Postal Code: _____

Telephone (Res): _____ (Bus): _____ (Cell): _____

Sex: (circle) M / F Date of Birth: D_____M_____Y_____ Marital Status: (circle) M W S D

Occupation:_____ Health Card No.: _____ Version Code: _____

E-mail: _____ Number of Children: _____ Ages: ____/____/____/____

Whom can we thank for referring you? _____
Do you give us permission to contact you via email with clinic updates and promotions (please circle)? YES NO
Do you give us permission to contact you via email with appointment reminders and scheduling (please circle)? YES NO

DOCTOR INFORMATION:

Family Doctor: _____ Telephone:_____ May we contact him/her? Y / N

INSURANCE INFORMATION (if applicable):

Do you have an Extended Health Plan: (circle) NO YES

Check coverage: ( ) Chiropractic ( ) Orthotics ( ) Acupuncture ( ) Massage

EMERGENCY CONTACT:

Name: _____ Telephone: _____

HEALTH HISTORY:

1. When did your symptoms first begin? _____

2. What is your greatest concern at this time? _____

3. Do you feel your problem is (circle one) a) temporary or b) permanent

4. Are you participating in any prolonged postures during your daily routine (ie. Repetitive lifting, sitting, driving)? Y / N
   If yes, please explain: _____

5. What activities are aggravating? _____

1) Balance	4) Gripping	7) Lifting	10) Reaching	13) Sleeping	16) Travelling
2) Bending	5) Housework	8) Pulling	11) Recreation	14) Standing	17) Walking
3) Fatigue	6) Kneeling	9) Pushing	12) Sitting	15) Stooping	18) Other _____

6. Which of the following provides relief? (circle):
Acupuncture / aquatherapy / changing position / chiropractic / electrical modalities (IFC/TENS) / exercise / Graston / heat / ice / lying down / massage therapy / NET / osteopathy / physiotherapy / rest / stretching / Other_____

7. PAIN DIAGRAM:

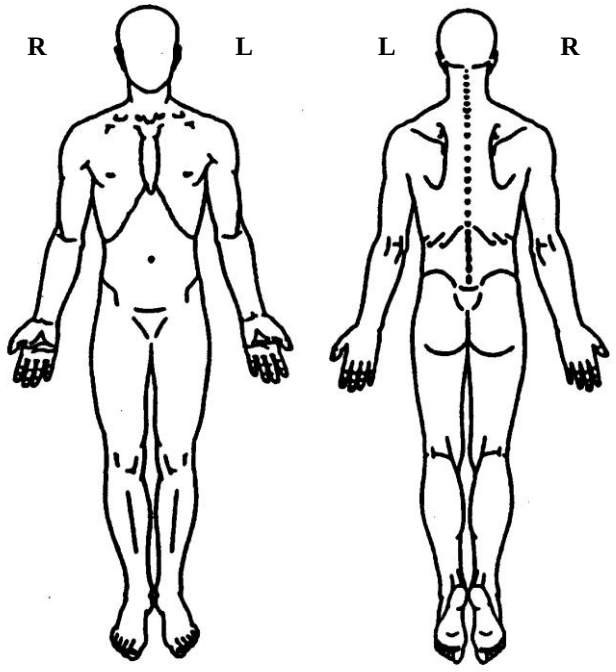
Check if you have any of the following pain symptoms:

□ Pain □ Numbness □ Weakness □ Electric Shock
□ Pins & Needles □ Itching □ Tingling

On the diagram, draw where you have these symptom. Use the following symbols:

Pain PPP Numbness OOO Weakness WWW Electric Shock SSS

Itching III Pins & Needles/Tingling ZZZ



	Pain Level [0-10]
Headaches	[ ]
Neck Pain	[ ]
TMJ	[ ]
Upper Shoulder	[ ]
Arm-pain, numb, weak	[ ]
Hand-pain, numb, weak	[ ]
Rib-pain, stiff, tight	[ ]
Mid Back (thoracic pain, stiff)	[ ]
Low Back (lumbar pain, stiff)	[ ]
Buttocks - pain, stiff, tight	[ ]
Leg - pain, numb, tingly, weak	[ ]
Foot - pain, numb, tingly, weak	[ ]
Other (specify below)	

_____

Please rate your pain on a scale from 0 (no pain) to 10 (worst pain ever)

0 1 2 3 4 5 6 7 8 9 10

Write any comments or concerns that you would like the doctor to focus on: _____
_____

8. Psychological stress can also play a role in the functioning of your nervous system. Please rate your overall mental / emotional stress level 0 (no stress) to 10 (extremely stressed)

0 1 2 3 4 5 6 7 8 9 10

9. Please indicate any treatments you have previously or are currently receiving for your condition:
_____

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10. Any previous surgeries (please indicate type of surgery and year): _____

11. For any problems experienced by you (use S-self) and/or anyone in your family (use F-family), please indicate as follows**:** ----------

AIDS	[ ]	Fainting	[ ]	Memory problems	[ ]
Arthritis	[ ]	Faulty posture	[ ]	Mental disorders	[ ]
Asthma	[ ]	Foot Trouble	[ ]	Nerve problems	[ ]
Bladder, kidney, bowel	[ ]	Heart disease	[ ]	Neurological disease	[ ]
Cancer of _____	[ ]	Hernia	[ ]	Obesity	[ ]
Cholesterol	[ ]	HIV (AIDS) exposure	[ ]	Osteoporosis	[ ]
Diabetes	[ ]	High blood pressure	[ ]	Seizures	[ ]
Digestive problems	[ ]	Hypertension	[ ]	Stroke	[ ]
Drug/Alcohol abuse	[ ]	Liver disease	[ ]	Thyroid disease	[ ]
Eyes, ear, nose, throat	[ ]	Lung problems/asthma	[ ]	Other _____	[ ]

12. What is your height: _____ Weight: _____ Any recent change in your weight (gain / loss)? Y / N

13. Do you smoke? Y / N If yes, for how long? _____ How many cigarettes per day? _____

14. Allergies: [ ] None [ ] Yes, if yes please indicate: _____

15. List any serious accidents, falls, hospitalization (type and year):
_____

16. Fractures: Which bones _____What age:_____

17. List present medications (please provide frequency and dosage if you can):
_____ _____ _____
_____ _____ _____

18. List present supplements (please provide frequency and dosage if you can):
_____ _____ _____
_____ _____

19. When did you last feel 100% healthy? _____ Is this one of your goals? (circle one) **YES** **NO**

☐ I have a specific problem and I would like only this problem addressed

☐ After my specific problem has been relieved, I am interested in learning about strategies to help ensure that it does not return.

☐ After my specific problem has been resolved, and I have learned ways to prevent it from reoccurring, I am also interested in learning other strategies to improve my overall health.

☐ I currently do not have any major symptoms and feel well but I am looking for strategies to assist me in reaching optimal health.

- **EXAM CONSENT:** I consent to an examination/treatment in this office and distribution of reports to appropriate professionals.
- **HEALTH CARD CONSENT:** I release my health card number by the Ministry of Health if requested by this office.
- **RELEASE OF INFORMATION:** I consent to the release of information to third party and other professionals.

_____ _____ _____
(Signature of patient/claimant, parent or guardian) (Date) (Witness)

We are fully compliant with both Federal and Provincial privacy laws. All information is kept secure and is not communicated to any party for any reason except that information which you approve. We would be pleased to discuss any privacy issues with you should you have any concerns.

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