PERFORMANCE HEALTH

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please let us know. All information that is gathered for this treatment is kept strictly confidential, except as required by law.

PATIENT INFORMATION (Please print)

Name: _____ Birthday: _____/_____/_____ MM/DD/YYYY

Address: _____ Apt# _____/_____/_____/_____
City Province Postal Code

Phone: Home #: _____ Cell #: _____ Gender: ☐ M ☐ F ☐ Other: _____

Email: _____ How did you hear about us? _____

Family Doctor: _____ Occupation: _____

Emergency Contact Name: _____ Phone #: _____

What brings you in today? _____

When did it start? _____ Has there been a medical diagnosis? _____

Are there any other areas of minor complaint or concern? _____

Is this pain the result of a: **Motor Vehicle Accident**? Yes / No or **Work Related Injury**? Yes / No

If Yes, date of accident: _____/_____/_____ MM/DD/YY Health Insurance: _____

Height: _____ Weight: _____(lbs) Shoe Size: (for Custom Orthotics) _____

MEDICAL/SURGICAL HISTORY

Please check if you have ever had:

- ☐ Arthritis
- ☐ Broken Bones
- ☐ Osteoporosis
- ☐ Blood Disorder
- ☐ Circulation Problems
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Depression/Anxiety
- ☐ Lung/Breathing problems
- ☐ Diabetes/High Blood Sugar
- ☐ Parkinson's Disease
- ☐ Thyroid Problems
- ☐ Cancer - Type: _____
- ☐ Ulcers/Stomach Problems
- ☐ Drug Resistant Infections
- ☐ Infectious Diseases
- ☐ Allergies
- ☐ Stroke
- ☐ Head Injury
- ☐ Multiple Sclerosis
- ☐ Seizures/Epilepsy
- ☐ Skin Disorders
- ☐ Kidney Problems
- ☐ Other: _____

Please check if you have experienced the following symptoms in the past year:

- ☐ Chest pain
- ☐ Heart palpitations
- ☐ Hoarseness
- ☐ Shortness of breath
- ☐ Coordination problems
- ☐ Weakness in arms or legs
- ☐ Loss of balance or falls
- ☐ Difficulty in walking
- ☐ Joint pain or swelling
- ☐ Pain at night
- ☐ Difficulty sleeping
- ☐ Difficulty swallowing
- ☐ Bowel problems
- ☐ Unexpected weight gain/loss
- ☐ Urinary problems
- ☐ Fevers/chills/sweats
- ☐ Headaches
- ☐ Hearing problems
- ☐ Other: _____

Have you ever had surgery? ☐ Yes ☐ No If yes, please describe and provide date:

1) _____ Date: _____
2) _____ Date: _____
3) _____ Date: _____

PLEASE TURN OVER TO CONTINUE

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PATIENT INFORMATION (Please print)

MEDICATIONS

Do you take any medications? ☐ Yes ☐ No If yes, please list below:

1) _____ 3) _____

2) _____ 4) _____

DIAGNOSTIC TESTS

Please indicate if you have had any of the following tests within the past year:

☐ X-Rays ☐ Bone Scan ☐ Ultrasound

☐ CT Scan ☐ EMG (Electromyogram) ☐ Angiogram

☐ MRI (Magnetic Resonance Imaging) ☐ NCV (Nerve Conduction Velocity) ☐ Stress Test

☐ Myelogram ☐ Arthroscopy

What was your area of imaging? : _____

CONTRAINDICATIONS TO SOME THERAPIES

Please indicate if you have been diagnosed or treated with:

☐ DVT and/or atherosclerosis ☐ Haemophiliac ☐ Pacemaker

☐ Active/suspected cancer ☐ Allergies (electrodes/gel/tape) ☐ Raynaud's Disease

☐ Pregnant Due Date: _____ ☐ Acute fever/illness ☐ Dermatitis

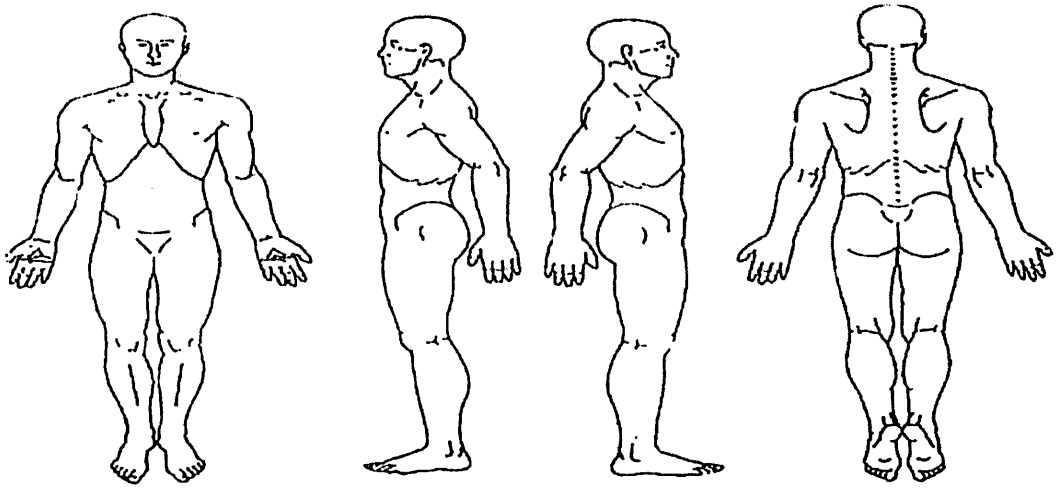
☐ Other: _____ area: _____

SYMPTOM DIAGRAM

Please indicate on the diagram below:

X – Pain/Stiffness **N** – Numbness/Tingling

What is your pain on scale from 1 to 10 (1 = mild pain, 10 = severe pain)? _____ / 10



Disclaimer:

I hereby certify that I have read and understand all of the questions relative to my health and medical history. I have completed the information accurately and am aware of no other health conditions not specifically mentioned in the above questionnaire. I hereby absolve Performance Health of all claims and responsibility for detrimental effects to my health as a result of treatment. I hereby certify that I have properly informed Performance Health of any known infectious diseases, high blood pressure, pregnancy and / or surgical implants.

Client Signature: _____ Date: _____/_____/_____ MM/DD/YY

PLEASE TURN OVER TO CONTINUE

PERFORMANCE HEALTH

2528 Dougall Ave. Windsor, ON N8X1 T6
Phone: (519) 966-3444
Fax: (519) 966-8885
www.phwindsor.com

Informed Consent to Treatment

Doctors of chiropractic, medical doctors, physiotherapists, acupuncturists and massage therapists may use manual therapy techniques such as spinal and extremity manipulation/mobilizations, soft tissue manipulation, acupuncture, moxibustion, cupping, electroacupuncture, exercises and physical therapy modalities. Health care providers are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) While rare, some patients have experienced rib fractures or muscle and ligament sprains or strains following spinal manipulation;

b) There have been reported cases of injury to a vertebral artery following cervical spinal manipulation. Vertebral artery injuries have been known to cause stroke, sometimes with serious neurological impairment and may on rare occasion result in serious injury. The possibility of such injuries resulting from cervical spinal manipulation is extremely remote;

c) There have been rare reported cases of disc injuries following cervical and lumbar spinal manipulation although no scientific study has ever demonstrated such injuries are caused, or may be caused, by spinal manipulation.

d) There is a small possibility that as a result of massage and manual muscle therapy the skin may locally be slightly red or sore and even less likely bruised.

I acknowledge I have discussed or have had the opportunity to discuss, with my Treatment Provider the nature and purpose of my treatment in general and my treatment in particular as well as the contents of this consent. I consent to the treatments offered or recommended to me by my Treatment Providers, I intend this consent to apply to all present and future care.

Missed Appointment Policy: Twenty four (24) hours notice is required if you need to cancel your appointment. You may do so via email or by telephone. If it is less than 24 hours before your appointment, you must telephone the clinic. **It is the clinic's policy to charge the patient $25 *for missed appointments without appropriate notice:*** _____ *(patient initials)*.

Dated this _____ day of _____, 20____.

_____ _____

Patient Signature Verification Signature

Name: _____ Name: _____

(Please print) (Please print)

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ELECTRONIC TRANSMISSION AUTHORIZATION AND CONSENT FORM

Consent to collect and exchange personal information

This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposed of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and/or plan abuse.

Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize the insurer and/or plan administrator and their service provider(s) to:

- use my personal information for the above purposes.
- exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

Additional Consent Applicable to Plan Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposed described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

Print Name	Signature	Date