Ottawa Chiropractic and Sports Injury Clinic

Confidential Patient Health Record

Patient information Date: _____/_____/_____

Name: _____
Date of birth (dd/mm/yy) _____/_____/_____ Age: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Telephone: Home _____ Work _____
Cell: _____ Email: _____
Occupation: _____

Emergency Contact: _____ Phone: _____
Relationship to contact: _____

Name of Medical Doctor: _____
Address: _____ May we contact your doctor? Y / N

How did you hear about the clinic?
Internet____ Ad___ Doctor ____ Other _____
Referral name: _____

Health History: *Please indicate conditions you are experiencing or have experienced*
If in your family health history please indicate with an "F"

Respiratory
- o Bronchitis
- o Asthma
- o Emphysema
- o Chronic Cough
- o Shortness of Breath
- o Diaphragm spasms /tightness

Skin/Infections
- o Plantar warts
- o Eczema
- o Hepatitis
- o HIV/AIDS
- o Bruise easily
- o Arthritis (type:_____)

Head/Neck
- o Headaches
- o Concussions
- o Throat infections
- o Vision problems
- o Ear infections
- o Hearing problems

Other Conditions
- o Diabetes
- o Epilepsy
- o Cancer
- o Crohn's disease
- o Gout
- o Fibromyalgia
- o Deep vein thrombosis
- o Osteoporosis

Digestive/Urinary System
- o Ulcer
- o Irritable Bowel
- o Recurrent infection
- o Kidney problems

Cardiovascular
- o High Blood Pressure
- o Low Blood Pressure
- o Blood Clotting Disorders
- o High cholesterol
- o Heart attack
- o Phlebitis
- o Stroke/CVA
- o Pacemaker
- o Heart Disease
- o Poor Circulation
- o Varicose veins

Other: _____

Personal information collected, used, stored and disclosed by this medical practice is confidential information. 24hrs notice is required to cancel or change appointments otherwise full charges apply.

Allergies: (all types)_____
_____
_____

Current Medication/Vitamins: _____
_____
_____
_____

Currently Pregnant: Yes / No If yes, due date: _____

Past/upcoming Surgeries:
_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____

Do you have any pins, wires, artificial joints or limbs: _____
_____
_____

Have you ever been to an Athletic Therapist before? Y / N
For what condition?_____
Area of Concern for this visit: _____

Are you coming here regarding an injury from a recent motor vehicle accident? Y / N or a workplace accident/injury? Y / N If yes, Date:_____

Informed Consent

I, _____ consent to an examination and treatment to be performed by a Certified Athletic Therapist (AT) /Registered Kinesiologist. The results of the examination will assist the AT in determining the appropriate treatment(s) to meet my specific needs and goals.

1. I understand (a) no guarantees have been made as to the results that may be obtained from Athletic Therapy; (b) Athletic Therapy does not provide an instant cure for injuries; (c) Athletic Therapist are not physician and do not diagnose illness or disease and Athletic Therapy is not a substitute for a medical examination.
2. I understand that Athletic Therapy includes, but is not limited to, massage, stretched, exercise, and modalities to assist in the healing process. I understand that my AT is providing Athletic Therapy services within the scope of practice as defined by the Canadian Athletic Therapist Association.
3. I will inform the AT if I am pregnant and have any other unapparent condition that could affect my treatment. I will also inform the AT if I experience some temporary muscle soreness during the extent of my treatments. I also understand and have been advised by the AT that my muscles may feel worse before they get better.
4. I am aware that the fees for Athletic Therapy are not covered by OHIP and that it is my responsibility to confirm whether any company that provides me with private health insurance will reimburse me for the cost of such Athletic Therapy.

I acknowledge that I have read this form fully and understand its contents. I acknowledge and understand that my Therapist must be aware of any existing medical conditions. I have completed my medical history form as provided by my Therapist. I further acknowledge that I have received and understood all explanations regarding the Athletic Therapy described above and that I have had the opportunity to ask questions and have received understandable answers. By signing this form, I consent to receiving such forms of Athletic Therapy as may be agreed to between the AT and myself.

_____ _____
Patient name (Please print) Date

_____
Patient's Signature (Parent's Signature or Legal Guardian if patient is under the age of 18 yrs of age.)