PERFORMANCE
INTEGRATED HEALTH
2630 Croydon Drive South Surrey BC V3Z 6T3
T 604 535 7705 E info@performancechiropractic.ca

Patient Information

Date

First name | Last name

Middle name(s) | I go by

Care Card/Services Card number (PHN)

Birthdate (yy/mm/dd) | Age | Please cirlce: Male Female Other

Home address

City | Postal code

Home telephone | Cellphone

Email (We will not share, rent or sell your email address.)

I would like to be reminded of my upcoming appointments by… ☐ Email ☐ Text ☐ Both Email and Text
I consent to Performance Integrated Health staff and practitioners corresponding with me via the email address I have provided. ☐ Yes ☐ No
If by Text, please provide the name of your cellphone carrier (eg. Telus)

I would like to receive Performance Integrated Health's free email newsletter featuring clinic news and health and wellness information. ☐ Yes ☐ No (You may unsubscribe at any time.)

Is this condition part of an **ICBC** or **WCB** Claim? ☐ Yes ☐ No **If yes, please ask for additional forms.**

Occupation | Business/employer

Do you have an extended health plan? ☐ Yes ☐ No

Name of current General Practitioner (MD)

Date of last visit to GP | Reason for last visit

Are you seeing a medical specialist? ☐ Yes ☐ No | Name of specialist

Reason for seeing specialist

Emergency contact | Telephone

How did you learn about Performance Integrated Health?
Online: ☐ Clinic website ☐ Facebook ☐ Google ☐ Instagram ☐ Twitter ☐ Yahoo ☐ Yellow Pages

Referred by (Give us a name – we would like to say thank you!)

☐ I live nearby Other:

Office use only MSP: ☐ Yes ☐ No W/C ☐ CE ☐ NL ☐ WE ☐

Confidential Health Information

Main health complaint

Other complaints

Have you had previous care from a... ☐ Chiropractor ☐ Massage Therapist ☐ Naturopath

If yes, name of practitioner _____ Approximate date of last visit _____

Did you have spinal x-rays? ☐ Yes ☐ No If yes, when?

Medications Please list any medications or supplements you are taking and state reasons for taking them.

Medications (prescription, over-the-counter)

Supplements (multivitamins, gingko, etc)

Surgeries/Hospitalizations Please list any surgeries you have had and the date.

Stress Level Overall stress level: ☐ none ☐ low ☐ medium ☐ high

Main reasons for stress

Exercise How often do you exercise?

Type of exercise

Smoking Do you currently smoke? ☐ Yes ☐ No How much? per day For how long? years

Goals What would you like to gain from today's visit?

What are the two most important health goals for you?

1. **2.**

Are you pregnant? ☐ Yes ☐ No ☐ Maybe If yes, what is your due date? _____

Do you have children? ☐ Yes ☐ No If yes, by... ☐ natural delivery ☐ caesarean delivery

Menstrual cycle: ☐ regular ☐ irregular ☐ cramps ☐ painful cycle

Date of your last annual Pap/Breast exam:

Review of systems

Please check the appropriate box for any of the following symptoms and add any comments you may feel are important.

General
- ☐ Insomnia
- ☐ Fatigue
- ☐ Weight loss
- ☐ Weight gain

Head
- ☐ Headache
- ☐ Dizziness
- ☐ Head trauma
- ☐ Fainting
- ☐ Blacking out

Eyes
- ☐ Itching/redness
- ☐ Change in vision
- ☐ Cataracts
- ☐ Light sensitivity
- ☐ Flashes in vision
- ☐ Spots in vision
- ☐ Glaucoma

Ears
- ☐ Impaired hearing
- ☐ Earache
- ☐ Dizziness
- ☐ Discharge
- ☐ Ringing/tinnitus

Mouth & Throat
- ☐ Bleeding gums
- ☐ Cold sores
- ☐ Sore throat
- ☐ Jaw/TMJ problems
- ☐ Hoarseness
- ☐ Swollen glands
- ☐ Goiter

Nose
- ☐ Hayfever
- ☐ Loss of smell
- ☐ Nosebleeds
- ☐ Sinus problems

Lungs
- ☐ Difficulty breathing
- ☐ Shortness of breath
- ☐ Persistent cough
- ☐ Coughing phlegm
- ☐ Coughing blood
- ☐ Asthma
- ☐ Pneumonia
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Infections

Vascular
- ☐ Angina
- ☐ Murmurs
- ☐ Heart disease
- ☐ Chest pain
- ☐ Palpitations
- ☐ Ankle swelling
- ☐ Cold feet/hands
- ☐ Leg cramps
- ☐ Calf pain
- ☐ Varicose veins
- ☐ Low blood pressure
- ☐ High blood pressure

Gastro-Intestinal
- ☐ Bloating/gas
- ☐ Heartburn
- ☐ Ulcers
- ☐ Liver disease
- ☐ Gall bladder disease
- ☐ Vomiting/nausea
- ☐ Abdominal pain
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stool
- ☐ Hemorrhoids
- ☐ Hernias

___ number of bowel movements per day

Gastro-Urinary
- ☐ Difficulty urinating
- ☐ Pain urinating
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Bed-wetting
- ☐ Urinary urgency
- ☐ Frequent urination
- ☐ Frequent infections
- ☐ Kidney stones

Neurological
- ☐ Seizures/epilepsy
- ☐ Strokes
- ☐ Tingling sensation
- ☐ Numbness
- ☐ Muscle weakness
- ☐ Difficulty walking
- ☐ Poor coordination
- ☐ Paralysis
- ☐ Speech problems
- ☐ Loss of memory

Muscle & Bone
- ☐ Joint pain
- ☐ Swollen joints
- ☐ Stiffness
- ☐ Muscle ache
- ☐ Foot trouble
- ☐ Arthritis
- ☐ Bone pain
- ☐ Fractures
- ☐ Dislocations

Skin
- ☐ Rash
- ☐ Itching/hives
- ☐ Changes in moles
- ☐ Acne
- ☐ Psoriasis
- ☐ Eczema

Endocrine
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Hormone therapy
- ☐ Thyroid problems
- ☐ Heat/cold intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Excessive sweating
- ☐ Night sweats

Emotional
- ☐ Depression
- ☐ Mood swings
- ☐ Anxiety/nervousness
- ☐ Tension
- ☐ Phobias
- ☐ Alcohol/drug abuse

Conditions
- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Cancer/tumor
- ☐ Chronic fatigue
- ☐ Eating disorder
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Headache unlike any ever experienced
- ☐ Heart condition
- ☐ Hepatitis
- ☐ High cholesterol
- ☐ Migraines
- ☐ Multiple sclerosis
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Polio
- ☐ Rheumatic arthritis
- ☐ Rheumatic fever
- ☐ TIAs (Transient Ischemic Attacks)

Using the following symbols, please indicate directly on the body diagrams below the area of your complaint and the type of pain experienced.

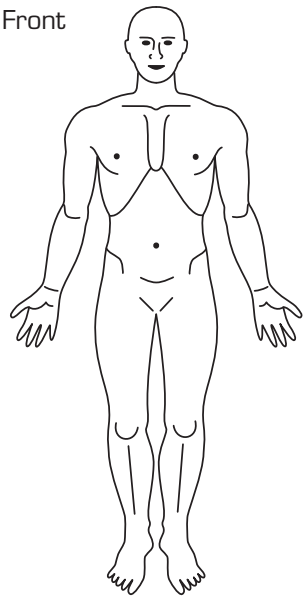
X Burning

○ Dull/achy

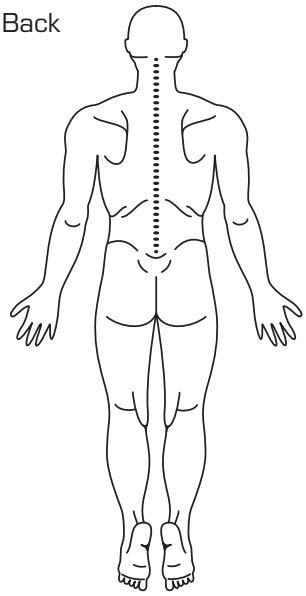
△ Sharp

☐ Numbness/tingling

Front



Back



Consent for Massage Therapy and Soft Tissue Manipulation

Please read the following carefully and enquire if you have any questions or concerns.

I hereby request and consent to the performance of massage therapy and other soft tissue procedures, including various forms of massage therapy, hydrotherapy, range of motion testing and orthopedic testing by the Registered Massage Therapist (RMT) listed below.

I have had the opportunity to discuss the nature and purpose of massage therapy with the RMT. I understand that results are not guaranteed.

I further understand and am informed that in the practice of massage therapy, as in all health care, there are some very slight risks to treatment, including but not limited to muscle strains and tenderness, stiffness, and sometimes slight bruising. I do not expect the RMT to be able to anticipate and explain all the risks and complications associated with soft tissues manipulations.

I wish to rely on the RMT to exercise judgement during the course of my treatment(s), to apply those treatments which he/she feels at the time, based on the facts known, are in my best interest.

Payment, changes to appointments and file sharing (require your initialing)

I accept full responsibility for any fees incurred during care and treatment, and am aware that I am responsible for payment at the time services are rendered. _____ (initials)

We require 24 hours of notice for any changes to, or cancellation of your appointment. All appointments missed, cancelled or rescheduled within 24 hours of the appointment will incur the full appointment fee. _____ (initials)

I consent to my file being shared if I decide to see another practitioner at Performance. _____ (initials)

I acknowledge that I have read this Consent and I have discussed, or have been offered the opportunity to discuss, with my Registered Massage Therapist the nature and purpose of massage therapy procedures, the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the massage therapy procedures recommended to me by my Registered Massage Therapist, and I intend this consent to apply to and cover the entire course of treatment(s) for my present condition.

Dated this day of ,20

Patient or Legal Guardian's Signature

Name

(please print)

Witness of Signature

Name

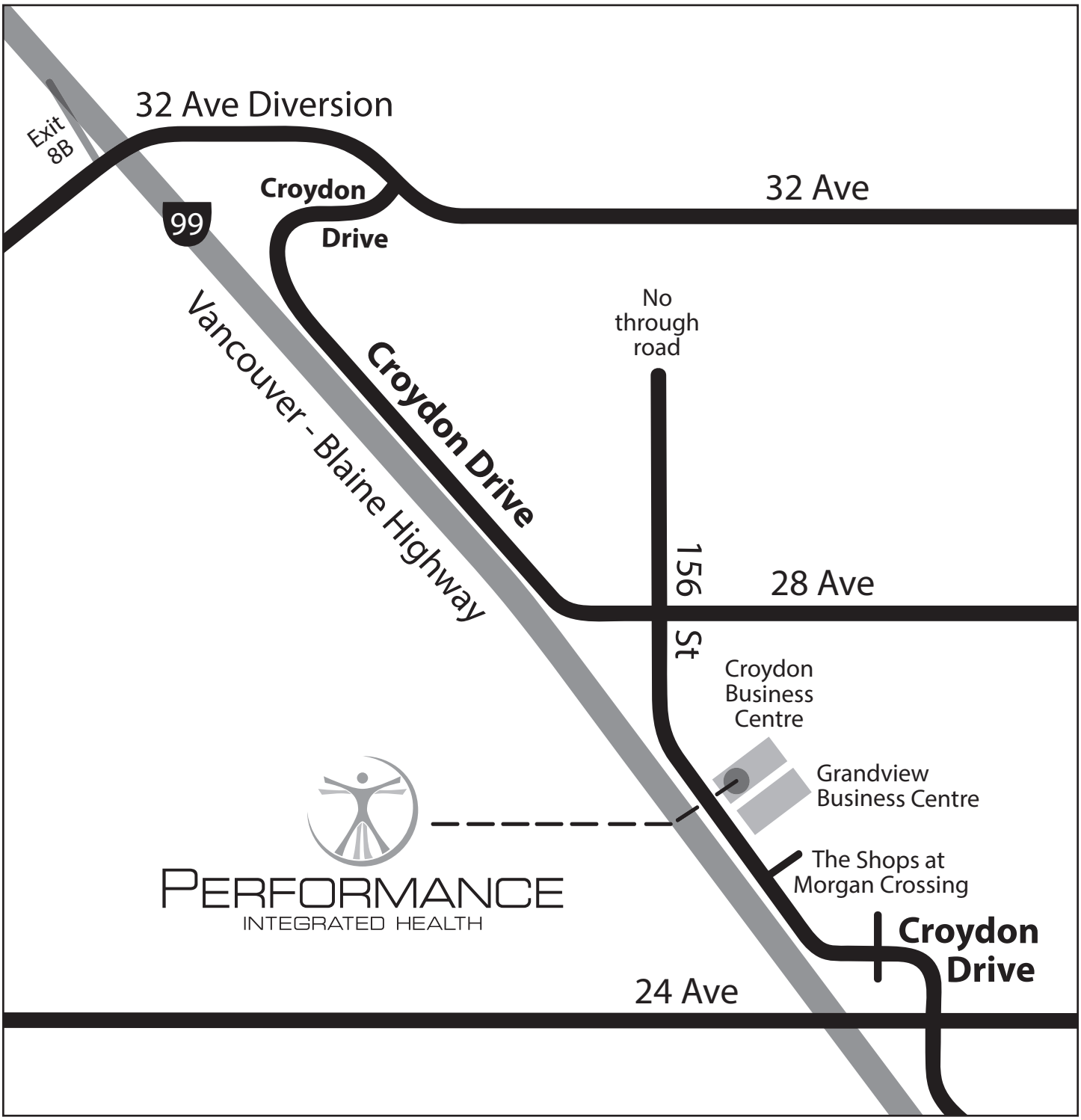
(please print)

Our Location

Performance Integrated Health is in the Croydon Business Centre.

120 - 2630 Croydon Drive South Surrey BC V3Z 6T3 T 604 535 7705

There is parking directly in front of our offices.



From the North (32 Ave):

Follow Croydon Drive until you reach the intersection with 156 St (where there is a 4-way Stop sign). Turn right, drive round the left bend and you're there.

From the South (24 Ave):

Stay on Croydon Drive until you drive past the two entrances to Morgan Crossing shopping centre and you will soon approach us at the Croydon Business Centre.