



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 circle: 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: _____

Immunizations

Did you receive general childhood vaccinations? Yes No

Check any other vaccines taken: Hepatitis A Hepatitis B Flu shot

Others (please list)

Allergies

Please list all allergies or hypersensitivities in the following categories.

Medications

Foods

Environmental/chemical

Medications

Please check if you take or use any of the following.

Alcohol Antacids Anti-inflammatory Caffeine Cortisone Laxatives Marijuana

Pain relievers Sleeping pills Tranquilizers

Other drugs (please list)

Were you ever on antibiotics for more than 1 month over the last 10 years? Yes No

Have you ever used probiotics (acidophilus) following antibiotic use? Yes No

Family History

Please check if you have a family history of any of the following. I don't know my family history

Arthritis Asthma/allergies Cancer Depression Diabetes Drug/alcohol abuse Epilepsy

High blood pressure High cholesterol Kidney disease Mental illness Stroke

Other (please list)

Sleep

Time you retire _____ Time you wake up _____

Do you have problems falling asleep? Yes No Staying asleep? Yes No

Do you wake rested in the morning? Yes No

Diet

Do you follow any particular diet regimens or restrictions? Yes No

Describe a typical day's dietary intake below.

Breakfast

Lunch

Dinner

Snacks

Fluids

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.

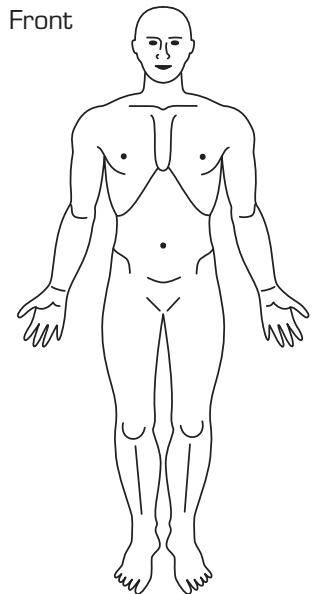
X Burning

O Dull/achy

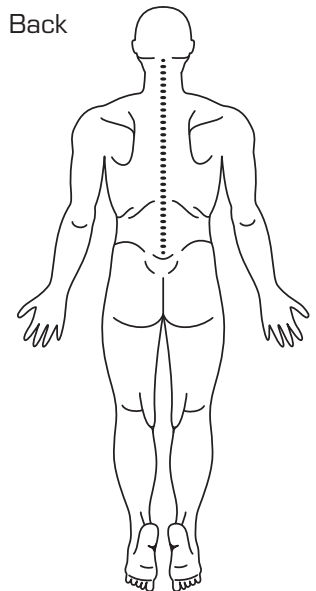
△ Sharp

□ Numbness/tingling

Front



Back



Declaration and Consent to Naturopathic Treatment

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

A Naturopathic Doctor (ND) will conduct a thorough case history and physical examination, and may utilize specific blood, urinary or other laboratory reports as part of your treatment work-up.

Statement of Acknowledgement

As a patient of Performance Integrated Health, I have read the information and understand that the form of medical care to be given me is based on Naturopathic and other supportive principles and practices. I recognize that even the gentlest therapies have potential complications in certain physiological conditions or in very young children or those on multiple medications.

The information I have provided is complete and inclusive of all health concerns, including risk of pregnancy and all medications, including over-the-counter drugs.

The slight health risks of some Naturopathic treatments include but are not limited to: aggravation of pre-existing symptoms; allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and spasms; disc injuries from spinal manipulations.

I also recognize the following:

Any treatment or advice provided to me as a patient of the clinic is not mutually exclusive from any treatment that I may now be receiving or may in the future receive from another licensed healthcare provider. I am at liberty to seek or continue medical care from a medical doctor or other healthcare provider licensed to practise in British Columbia.

I understand that a record of my visits will be kept. This record will be kept confidential and will not be released without my consent. I understand that I may look at my medical records at any time and can request a copy of them.

I understand that the ND reserves the right to determine which cases fall outside his/her scope of practice, in which event the appropriate referral will be recommended. I also confirm that I have the ability to accept or reject this care of my own free will and choice, and that I am not an agent of any private, local, county, provincial or federal agency to gather information without stating so.

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 Naturopathic Doctor the nature and purpose of naturopathic treatments, the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the naturopathic treatments recommended to me by my Naturopathic Doctor, 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

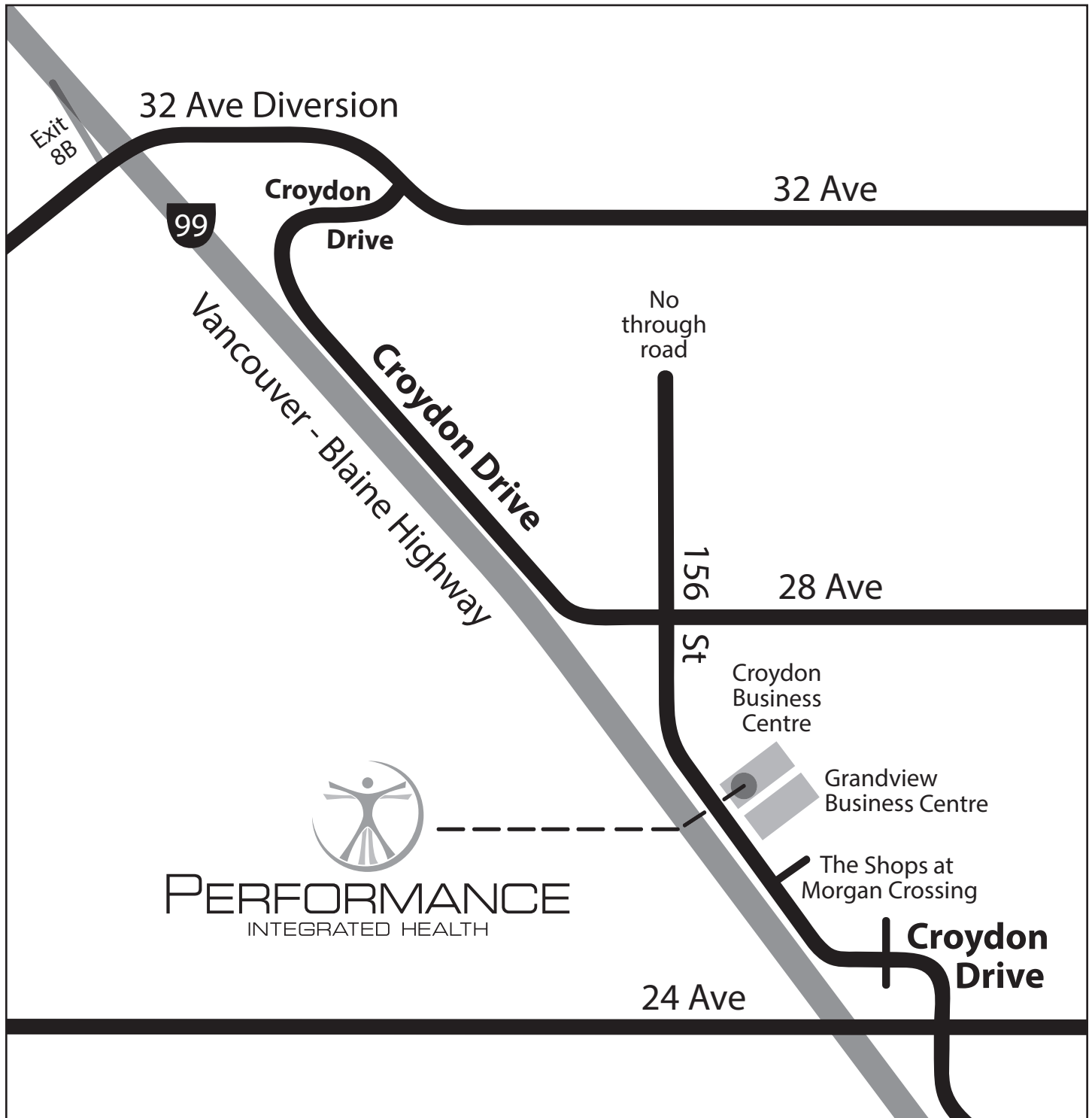
Name

(please print)

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.