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.

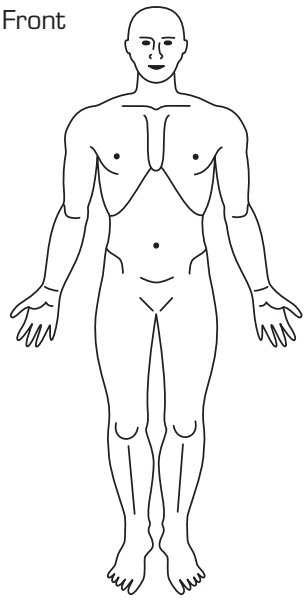
X Burning

○ Dull/achy

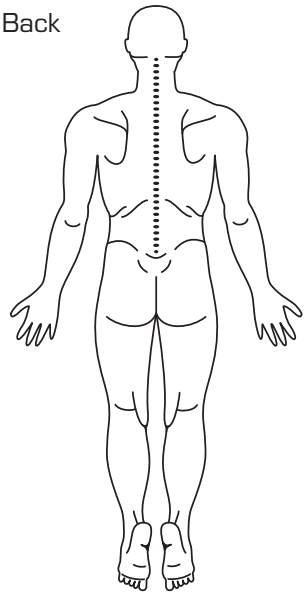
△ Sharp

☐ 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.

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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)

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**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

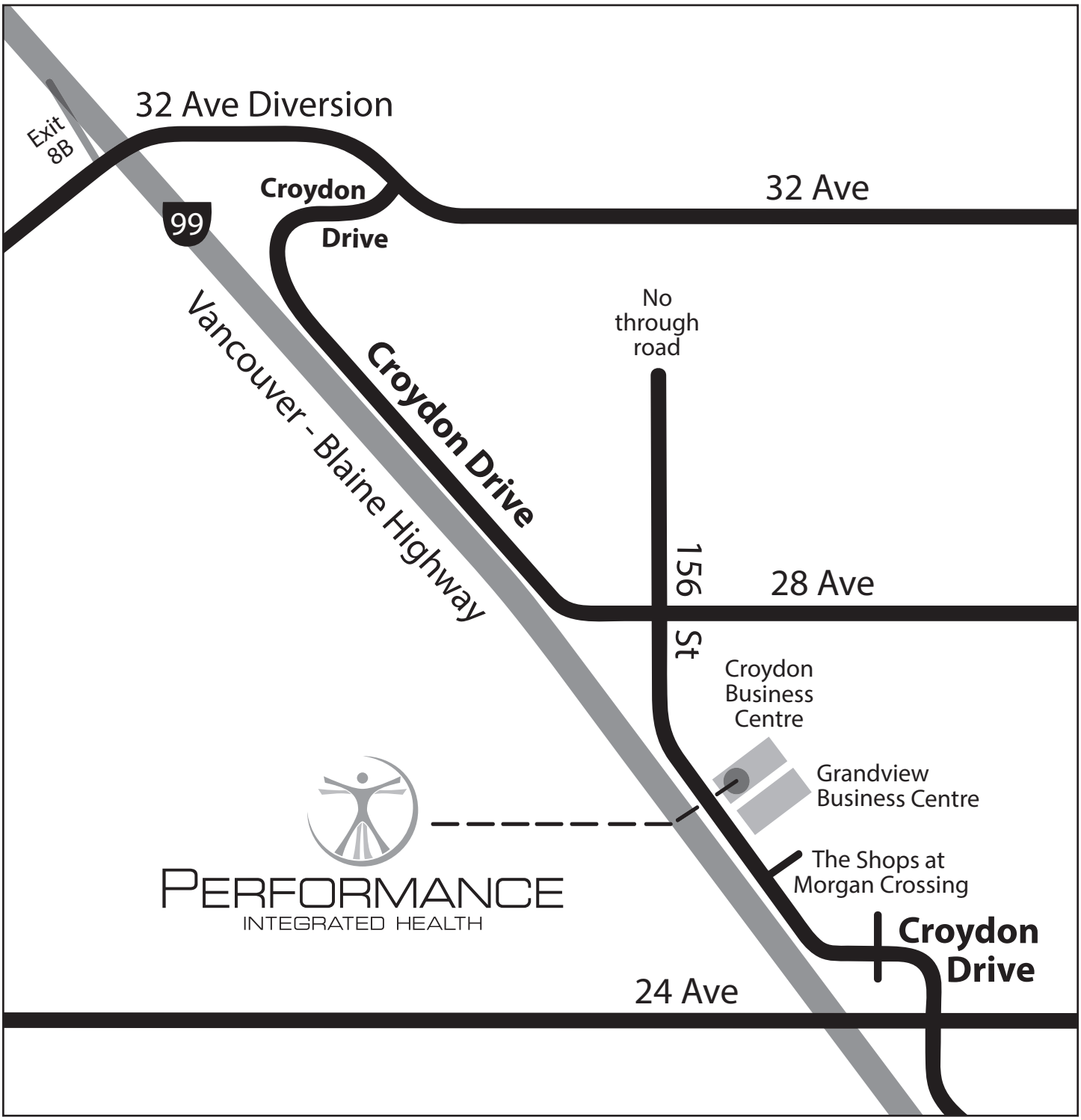
(please print)

# 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.