THE PROACTIVE ATHLETE

Patient Name:_____

NEW PATIENT FORM

☐Mr. ☐Mrs. ☐Ms. ☐Miss ☐Dr. _____ _____ _____
(Surname) (Given Name) (MI)

Date of Birth: ____/_____/_____ (mm/dd/yyyy) Age:_____ Sex: ☐ M ☐ F

Address:_____ APT/UNIT:_____

City:_____ Province:_____ Postal Code:_____

Phone: ( )_____ ( )_____ ( )_____
Home phone# cell phone # work phone #

Leave messages? Y ☐ N ☐ E-mail address:_____

Check If You Do Not Want To Receive Our Electronic Newsletter ☐

Occupation:_____ Employers Name:_____

Emergency Contact:_____ Relationship:_____

Emergency Contact Phone Number: ( )_____

How did you hear about us? ☐SST ☐Sign ☐Friend ☐Dr. Other:

HEALTH INFORMATION

Previous Medical Experience

Previous Chiropractor:_____ Phone #:_____

Medical Doctor Name:_____ Phone #:_____

Do you give authorization for the exchange of information with your medical doctor? Y ☐ N ☐

Do you have any extended health coverage? ☐ Y ☐ N Insurer:_____

ABOUT YOUR VISIT

Please specify the reason for today's visit:_____

How long has this condition been bothering you?_____

Have you had this pain before? ☐ Y ☐ N If yes, when?_____

Are the symptoms you are experiencing: ☐ getting worse ☐ Remaining the same ☐ Getting better

What types of treatment (if any) have you received for this condition?_____

Have you had any: ☐X-Ray ☐MRI ☐CTscan ☐Ultrasound If so, when?_____

Are the injuries the result of a workplace accident? ☐ Y ☐ N
(If yes, please fill in the following information)
Date of accident: _____/_____/_____ (mm/dd/yyyy) WSIB Claim Number_____
Employer name and telephone number:_____

Are the injuries the result of a motor vehicle accident? ☐ Y ☐ N
(If yes, please fill in the following information)
Date of accident: _____/_____/_____ (mm/dd/yyyy) Policy claim Number_____
Insurer name and telephone number:_____

Broken bones or Surgeries:_____ When?_____

Do you have any other conditions that should be brought to the Doctors attention?:

3018 New Street Unit 3, Burlington ON, L7N 1M5
P: 905-632-2728 F: 905-632-2951

□ Dr. Peter Kissel □ Dr. Dave Schenkel □ Dr. Adam Dunn

□ Carolynn Eng, PT Init. _____

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Patient Name:_____

FAMILY HEALTH HISTORY

Please check if you or anyone in your family have any of the following:

□ Cancer	____Myself	____Mother	____Father	____Sibling	____Other (specify)_____
□ Heart Disease	____Myself	____Mother	____Father	____Sibling	____Other (specify)_____
□ Stroke	____Myself	____Mother	____Father	____Sibling	____Other (specify)_____
□ Diabetes	____Myself	____Mother	____Father	____Sibling	____Other (specify)_____
□ High Cholesterol	____Myself	____Mother	____Father	____Sibling	____Other (specify)_____
□ Hypertension	____Myself	____Mother	____Father	____Sibling	____Other (specify)_____

Other conditions:_____

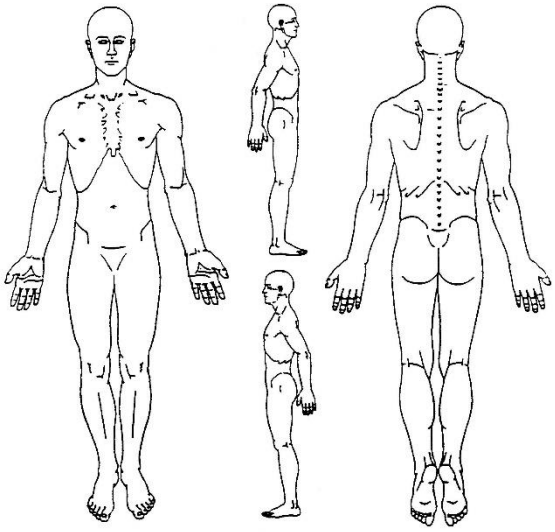
SOCIAL HISTORY

Do you smoke?	☐ Y ☐ N	If yes, how many packs/day? _____ For how long? _____
Do you consume alcohol?	☐ Y ☐ N	If yes, how many drinks/week?_____
Do you exercise?	☐ Y ☐ N	If yes, how many times/week?_____

SYMPTOM DIAGRAM

Please mark the areas on your body which represent
The pain(s) of sensation(s) you are experiencing.
Use the symbols below.

Numbness	========== ==========
Pins & Needles	....
Dull & Aching	******* *******
Burning	XXXXXXXX XXXXXXXX
Sharp & Stabbing	////////// //////////
Stiff & Tight	22222222 22222222



Numeric Pain Rating Scale

On the scale below, please indicate the intensity of the pain at its LOWEST and HIGHEST level:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain ever

Health Status Survey: Please circle below any condition you have had or presently have

NEUROLOGICAL
- Dizziness
- Fainting
- Fevers
- Headache
- Loss of sleep
- Neuralgia
- Numbness
- Sweats
- Weight loss
- Tremors

RESPIRATORY
- Smoking
- Chest Pain
- Chronic cough
- Difficulty breathing

CARDIOVASCULAR
- Anemia
- Rapid/slow heart beat
- Ankle swelling
- High/low blood pressure

Do you wear orthotics?
- Yes
- No

If yes, how old are they? _____

SURGICAL HISTORY:

_____
_____
_____
_____

Pregnant: YES NO
Due date:_____

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MEDICATIONS AND SUPPLEMENTS

Current medication and supplement list: (Please include name and dosage)

Medication 1:_____ Supplement 1:_____
Medication 2:_____ Supplement 2:_____
Medication 3:_____ Supplement 3:_____

TERMS, POLICIES, CONSENT TO EXAMINATION AND COLLECTION, USE, AND DISCLOSURE OF PERSONAL INFORMATION

By signing below, you are agreeing to the following terms and policies, consent to examination, and consent for collection, use, and disclosure of personal information at The Proactive Athlete Inc. If you have any questions or concerns, please speak with your healthcare provider.

Terms and Policies

We require 24 hours' notice to cancel or reschedule an appointment to allow our clinic to best accommodate other patients. All patients who cancel with fewer than 24 hours' notice will be subject to the full service fee.

Consent to Examination

All healthcare providers including Doctors of Chiropractic who conduct physical examinations are required to advise patients that there are some risks associated with such examination. I understand and am informed that as in all healthcare, a physical examination is meant to provide the healthcare professional with the opportunity to obtain useful information about individuals.

I further understand that there are some very slight risks to the examination that include but not limited to an aggravation of symptoms or the need for further diagnostic testing. I understand that I will have the opportunity to discuss the details of the examination with the healthcare professional at The Proactive Athlete Inc. and I understand that I am able to discuss the nature and purpose of the examination at any time as well as the contents of this consent. I hereby consent to the examination offered or recommended to me by The Proactive Athlete Inc.

Consent for collection, use, and disclosure of personal information

All personal information, including medical information collected will remain safe and secured and will not be shared with anyone without patient permission. This information may be collected via phone, personal interview, direct examination, transfer of medical information from other healthcare professionals, and third parties including insurance companies.

Personal information will only be seen by the healthcare professionals and administration at The Proactive Athlete Inc. In an event where personal information is required by insurance companies, regulatory bodies, and healthcare professionals, verbal consent will be obtained before information is transferred.

For further information on the Personal Information Protection Electronic Document Act visit www.prvicom.gc.ca.

By signing this form, I hereby consent to the collection, use, and disclosure of my personal information._____

Patient Name:_____ Signature of patient (or guardian)_____

Signature of Health Professional:_____ Date: _____/_____/_____ (mm/dd/yyyy)

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Verbal Consent To Examine ☐

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