Orthopedic and Sports Medicine/Medical Acupuncture
Helping Bodies…Heal Themselves

CLIENT INFORMATION

Client's Name:_____

Street Address:_____ Apt.:_____

City:_____ Province:_____ Postal Code:_____

Home Phone:_____ Work Phone:_____ Cell:_____

Fax #:_____ E-mail:_____

Parent/Guardian Name(s) (if client is a child):_____

Employer:_____ Occupation:_____

Address:_____ Phone:_____

May we call you at work? ___YES ___NO Whom may we thank for referring you?_____
Preferred Appointment Times:_____

EMERGENCY INFORMATION

In case of emergency, please contact: Name:_____ Phone:_____

Relationship:_____

Name of Spouse/Partner:_____

MEDICAL INFORMATION

Medical Alerts:_____ Allergies (e.g. latex):_____

Surgical Implants (e.g. artificial joint)_____

Family Physician:_____ Other Practitioners: (address and phone)
Address: _____ 1. _____
_____ _____
Phone: _____ _____
_____
Medical Specialists:_____ 2. _____
_____ _____
_____ _____

I understand that payment is expected on the day of each treatment. I am responsible for all charges, regardless of insurance coverage. I understand that all information will be held strictly confidential.

CLIENT OR GUARDIAN SIGNATURE:_____
DATE: _____

Revised October, 2014

Aurora Massage and Chiropractic Wellness Centre
150 Hollidge Blvd Unit C3 Aurora ON L4G 8A3 f: 905.727.4400 t: 905.727.4465

OrthoSport
Physical Therapy Center

Orthopedic and Sports Medicine/Medical Acupuncture
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INITIAL EVALUATION (REVISED 2016)

All information is confidential and part of your health record:

NAME:_____ DATE OF BIRTH:_____

DATE:_____ REFERRED BY:_____

MAIN COMPLAINT:_____

MEDICAL DIAGNOSIS:_____

FUNCTIONAL INQUIRY:

Head/Neck:
- ❑ Headaches
- ❑ Migraines
- ❑ Jaw pain
- ❑ Whiplash
- ❑ Dental problems

Eyes:
- ❑ Vision problems/loss
- ❑ Watery, itchy, burning
- ❑ Glaucoma
- ❑ Conjunctivitis

Ears:
- ❑ Ringing in ears
- ❑ Hearing loss
- ❑ Earaches
- ❑ Ear infections

Nose:
- ❑ Stuffy
- ❑ Sinus problems
- ❑ Hay fever
- ❑ Sneezing attacks
- ❑ Allergies

Mouth/Throat:
- ❑ Chronic cough
- ❑ Sore throat, hoarseness
- ❑ Loss of voice
- ❑ Canker sores
- ❑ Pneumonia
- ❑ Pleurisy
- ❑ Seasonal affective disorder (SAD)
- ❑ Chronic cough

Cardiovascular System:
- ❑ Heart condition/disease
- ❑ Elevated Cholesterol
- ❑ Angina
- ❑ History of Heart Attack
- ❑ Thrombosis
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Atherosclerosis
- ❑ Chest pain
- ❑ Irregular or skipped heartbeat
- ❑ Pacemaker
- ❑ Congestive Heart Failure

Back/Spine:
- ❑ Degenerative discs
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Osteopenia
- ❑ Restricted motion
- ❑ Joint stiffness
- ❑ Pain

Digestive:

GU (gynecological problems):
- ❑ Kidney
- ❑ Miscarriages #_____
- ❑ Infertility
- ❑ **Pregnant at this time ?**
- ❑ Pregnancies #_____
- ❑ Children living #_____
- ❑ Menstrual problems
- ❑ Endometriosis
- ❑ Bladder infections
- ❑ Candida
- ❑ Frequent urination
- ❑ Urinary incontinence
- ❑ Pelvic inflammatory disease
- ❑ Herpes
- ❑ Fibroids, cysts

Male:
- ❑ Elevated PSA
- ❑ Prostatitis

Endocrine System:
- ❑ Thyroid condition
- ❑ Hemophilia
- ❑ Hormone imbalance
- ❑ Night sweats
- ❑ Menopause
- ❑ Premenopause
- ❑ Fibrocystic breasts
- ❑

- ❑ Difficulty swallowing
- ❑ Extensive dental work

Chest:
- ❑ Shortness of breath
- ❑ Asthma
- ❑ Emphysema
- ❑ Bronchitis
- ❑ Hyperventilation
- ❑ Lung infections (e.g. TB)

(gastrointestinal system):
- ❑ Hiatal hernia
- ❑ Heartburn
- ❑ Ulcer
- ❑ Irritable bowel
- ❑ Diarrhea
- ❑ Constipation
- ❑ Bloating, gas, belching
- ❑ Nausea, vomiting
- ❑ Intestinal/stomach pain
- ❑ Gallstones
- ❑ Hepatitis
- ❑ Diabetes

Skin:
- ❑ Rashes, dry skin, hives
- ❑ Acne
- ❑ Hair loss
- ❑ Excessive hair
- ❑ Excessive sweating
- ❑ Plastic Surgery
- ❑ Infections

Extremities:
- ❑ Joint stiffness
- ❑ Restricted motion
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Muscle pain
- ❑ Pain sites_____

_____

CNS:
- ❑ Epilepsy
- ❑ Seizures
- ❑ Dizziness
- ❑ Fainting
- ❑ Insomnia
- ❑ Poor balance
- ❑ Poor coordination
- ❑ Stroke
- ❑ Pins n' needles
- ❑ Numbness

_____

_____

- ❑ Other neurological problems e.g. carpal tunnel/sciatica/MS:

_____

_____

Energy/Activity:
- ❑ Exhaustion/fatigue
- ❑ Apathy, lethargy
- ❑ Hyperactivity
- ❑ Restlessness

Mind:
- ❑ Poor memory
- ❑ Confusion
- ❑ Poor comprehension
- ❑ Poor concentration
- ❑ Difficulty making decisions
- ❑ Learning disabilities
- ❑ Stuttering/stammering
- ❑ Loss of short term memory

Emotions:
- ❑ Mood swings
- ❑ Anxiety, fear, nervousness
- ❑ Depression
- ❑ Anger, irritability, aggressiveness

Other:
- ❑ AIDS
- ❑ Cancer
- ❑ Chronic fatigue
- ❑ Chronic infections
- ❑ Possible pregnancy
- ❑ Fibromyalgia
- ❑ Swelling
- ❑ Varicose veins
- ❑ History of Phlebitis
- ❑ _____
- ❑ _____

ACTIVITIES OF DAILY LIVING:

Walking tolerance is _____

Standing tolerance is _____

Sitting tolerance is _____

Lying tolerance is _____

Work tolerance is _____

Driving tolerance is _____

How many hours do you sleep at night?_____

How would you consider your present level of activity? _____Poor _____Fair _____Good

How would you describe your GENERAL HEALTH STATUS? _____

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LIST ACCIDENTS/INJURIES/TRAUMAS WITH DATES:

_____

LIST OPERATIONS WITH DATES:

LIST MEDICATIONS AND THEIR FUNCTION: (prescription and non-prescription)

VITAMINS:

HEALTH HABITS:

Tobacco: How many cigarettes/day?_____ How many cigars/day?_____
Alcohol: How many glasses of wine/day?_____ How many/week?_____
How many glasses of beer/day?_____ How many/week?_____
How many oz. of liquor/day?_____ How many/week?_____
Caffeine: How many 6 oz. cups of coffee/day?_____
How many 6 oz. cups of tea/day?_____
How many cans of soft drinks with caffeine/day?_____
Water: How many glasses of water/day?_____

EXERCISE:

❑ 5-7 times per week	❑ Run, jog, skip rope
❑ 3-4 days per week	❑ Weight lift
❑ 1-2 days per week	❑ Swim
❑ 45 minutes or more duration/workout	❑ Boxing
❑ 30-45 minutes or more duration/workout	❑ Yoga
❑ Less than 30 minutes duration/workout	❑ Other
❑ Walk	

NUTRITION

How would you rate your dietary intake? _____Poor _____Fair _____Good _____Excellent

Describe a typical meal plan for a day._____

_____

Other health disciplines that you have initiated? e.g. acupuncture, chiropractic, homeopathy, massage, psychotherapy, etc.

_____

_____

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CONSENT TO TREAT

Dear Client:

Physiotherapy is a manual therapy form where the health practitioner places his/her hands on your body. In assessment and treatment, skeletal landmarks are used to determine soft tissue diagnosis and develop courses of treatment. The physiotherapist will prescribe patient education, and specific exercises for their condition.

After the evaluation is completed, a discussion of the findings follows and treatment needs are outlined.

By signing this form, you give permission to your therapist to proceed in the evaluation and acknowledge that you have had all your questions answered to your satisfaction.

Your participation in your healing process is significant. Ultimately, healing occurs as the body taps into its own innate capacity to restore itself. Your body is best able to use this capacity when we work together.

NAME (PLEASE PRINT): _____

CLIENT SIGNATURE: _____

THERAPIST/WITNESS SIGNATURE: _____

Date: _____

Revised October 2014

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Informed Consent for Acupuncture Treatment

Please Read Carefully

I hereby request and consent to the performance of acupuncture.

I understand that in the practice of acupuncture there are some risks to treatment including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock convulsions, possible perforation of internal organs and stuck needles.

I do not expect the physiotherapist performing acupuncture to be able to anticipate and explain all possible risks and complication of treatment and I wish to rely on the physiotherapist performing acupuncture to exercise judgement during the cause of treatment which he/she thinks at the time based upon the facts then known, is in my best interest.

I have read the above consent form. I have also had an opportunity to ask questions about its content and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire cause of treatment for my present and future conditions for which I seek treatment.

Female Patients

I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

Patient Full Name:_____

Patients Signature:_____

Date:_____