RougeHealthSolutions

General Information

Name: Mr. / Mrs. / Miss / Ms. / Dr.
First_____ Last_____

Date of Birth: D_____M_____Y_____ Age: _____

Address: _____ Postal Code:_____

Home Phone: ( )_____ Work or Other: ( )_____

Email Address: _____
*****I wish to receive the RHS newsletter and may withdraw consent at any time*****

Occupation: _____

Is this a Workers Compensation Injury? Yes □ No □ Claim Number:_____

Is this a Motor Vehicle Accident Injury? Yes □ No □ Claim Number: _____

How did you choose our office? _____

Previous Chiropractic/Physiotherapy/Massage? Yes □ No □ (please circle all that apply)

Family Doctor's name & phone number: _____
Address or Intersection: _____

Emergency Contact (name, phone#, relation)_____

I understand that OHIP no longer assumes responsibility for any part of the treatment fees and therefore I am responsible for the full fee for any service rendered.

We require <u>24 hours notice</u> to cancel any appointments or a <u>missed non-reimbursable</u> appointment fee may apply.

I certify that the above information is both accurate and correct. I understand that Rouge Health Solutions will take every reasonable precaution to protect this confidential information.

I understand that some or all of my personal or medical information may be shared between my treating practitioners at Rouge Health Solutions and/or medical doctor as necessary to optimize my treatment plan and recovery.

I agree to pay any and all fees associated with my treatment at Rouge Health Solutions that is not covered by my personal health benefits.

By signing this form, I have read and understand the above information and give written consent to the assessment and treatment provided by the health care provider. I understand that I can withdraw my consent at any time.

Signature: _____ Date: _____

110-285 Lawson Rd Scarborough, ON M1C 2J6 (416) 724-6532

Name: _____ Date: _____

What is the reason for your visit today? _____

How long have you had the symptoms? _____

What type of therapies have you tried for this problem(s)? _____

Have you had x-ray/CT/MRI for your current complaint? _____

List any current health problems you are being treated for? _____

Please list any Medications, vitamins or supplements you currently taking _____

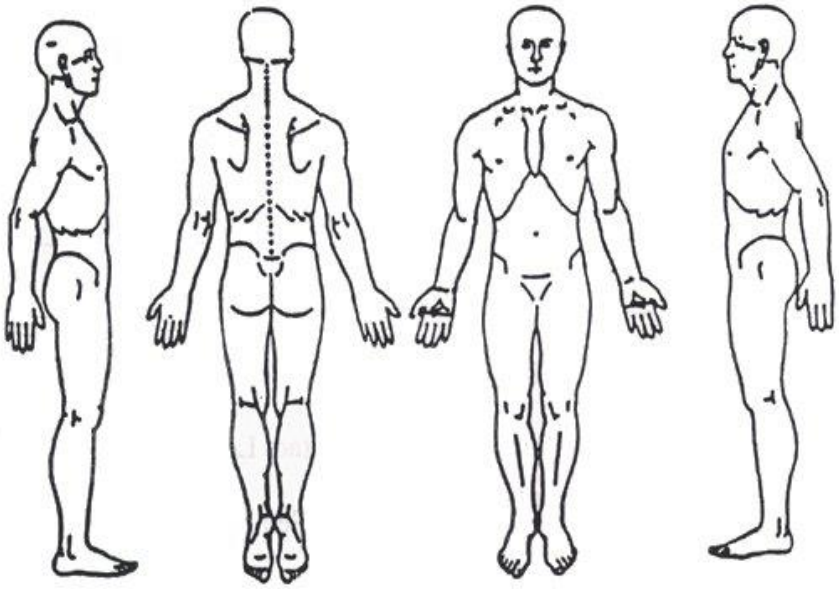
_____

Is there any history of serious illness or arthritis in your family? _____

Do you have ANY medical conditions we should know about? _____

HAVE YOU EVER:	YES	NO	Describe
Been treated for a spine or nerve disorder?	☐	☐	_____
Had any serious illness?	☐	☐	_____
Had any type of surgery?	☐	☐	_____
Been in a motor vehicle accident?	☐	☐	_____
Been knocked unconscious?	☐	☐	_____
Broken a bone?	☐	☐	_____
Been hospitalized?	☐	☐	_____

Please fill in diagrams below to illustrate your current complaint:



S-Sore ST-Stiff A-Achy SH-Sharp Pain N-Numb W-Weak R-Radiating T-Tingling

****Make a mark on the line at the point which represents your current level of discomfort****

No discomfort **Intolerable pain**

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Name: Date:

PAST AND PRESENT HEALTH SYMPTOMS

Please **CIRCLE** any condition or symptom **PRESENTLY** causing you a problem

Please **UNDERLINE** any conditions or symptoms which have troubled you in the **PAST**

GENERAL SYMPTOMS
Headaches
Dizziness
Clumsiness
Fainting
Blackouts
Loss of consciousness
Convulsions
Sweats
Fever
Nervousness
Loss of weight
Numbness or tingling

MUSCLES & JOINTS
Stiff neck
Back ache
Swollen joints
Painful tailbone
Foot trouble
Shoulder pain
Elbow pain
Wrist pain
Hand pain
Hip pain
Knee pain
Arthritis
Weakness or loss of strength

EYE, EAR, NOSE & THROAT
Blurred vision
Failing vision
Double vision
Eye pain
Deafness
Earache
Ringing or buzzing in ears
Frequent colds
Sinus infection
Enlarged thyroid
Difficulty swallowing
Speech impediment

RESPIRATORY
Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficulty breathing
Asthma

CARDIOVASCULAR
Bleeding disorder
High blood pressure
Pain over the heart
Stroke
Hardening of the arteries
Varicose veins
Swelling of the ankles
Poor circulation
Heart or blood disease
Angina

GENITOURINARY
Trouble urinating
Blood in urine
Kidney infection
Bed wetting
Prostate trouble

G.U. FOR WOMEN
Painful menstruation
Excessive flow
Hot flashes
Irregular cycle
Cramps or backache
Vaginal discharge
Swollen breasts
Lumps in breasts

	YES	NO
Have you ever been on birth control pills?	☐	☐
Are you currently taking birth control pills?	☐	☐
Are you pregnant?	☐	☐

Due Date:

SKIN
Rashes, itching
Bruise easily
Dryness
Boils
Hives (allergy)

GASTROINTESTINAL
Poor appetite
Indigestion
Excessive hunger
Belching or gas
Nausea
Vomiting
Constipation
Diarrhea
Hemorrhoids
Jaundice
Gallbladder trouble
Ulcer
Diabetes

GENERAL

	YES	NO
Are you a smoker?	☐	☐

Average weekly alcohol intake_____

Please inform the doctor or therapist if you have ever tested HIV positive or have ever been diagnosed with cancer or serious disease.

Medical History Update (To be filled out by therapist):
1._____ 2. _____ 3. _____ 4. _____