Binbrook Chiropractic & Physiotherapy
3064 Regional Road 56 Binbrook, ON L0R 1C0

Dr. Harnek Gill B.Sc., D.C

HEALTH HISTORY FORM

For Your Information:
An accurate health history is important to ensure that it is safe for you to receive a treatment. If your health status changes in the future, please let us now. All information gathered for this treatment is confidential except as required or allowed by law or to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____ Preferred Name (if any): _____

Address: _____ Today's Date: _____

City: _____ Postal Code: _____

Telephone Number (Home): _____ (Work): _____ (Cell):_____

E-mail Address: _____

Date of Birth: _____/_____/_____ Gender: M / F Occupation: _____
Month Day Year

Primary Care Physician: _____ Address: _____

Previous Chiro / Physio / Massage Care:_____ Last seen:_____

For what condition:_____ Results:_____

MVA or WSIB Claim number: _____

Emergency Contact Name and Phone Number:_____

Health History: please indicate conditions you are experiencing, or have experience.

Respiratory
- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema
- ☐ other _____

Cardiovascular
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ CCHF
- ☐ heart attack
- ☐ phlebitis
- ☐ stroke/CVA
- ☐ pacemaker or similar device
- ☐ other _____

Family History
- ☐ arthritis
- ☐ cancer
- ☐ diabetes
- ☐ heart disease/stroke

Other Conditions
- ☐ diabetes: onset _____
- ☐ allergies _____
- ☐ cancer
- ☐ arthritis
- ☐ migraines &/or headaches
- ☐ loss of sensation
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss
- ☐ skin conditions
- ☐ hepatitis
- ☐ TB
- ☐ HIV
- ☐ other _____

_____

Cigarette/Tobacco Consumption
- ☐ yes – amount _____/day
- ☐ no

Women
- ☐ pregnant:- due: _____

Soft Tissue/Joint Discomfort
- ☐ neck
- ☐ low back
- ☐ mid back
- ☐ upper back
- ☐ shoulders
- ☐ arms
- ☐ hands
- ☐ hips
- ☐ legs
- ☐ knees
- ☐ feet
- ☐ other _____

Rate your General Health
- ☐ above average
- ☐ average
- ☐ below average

Continued on back of page…

Are you currently taking any medications? _____

What is your **Current complaint?** _____

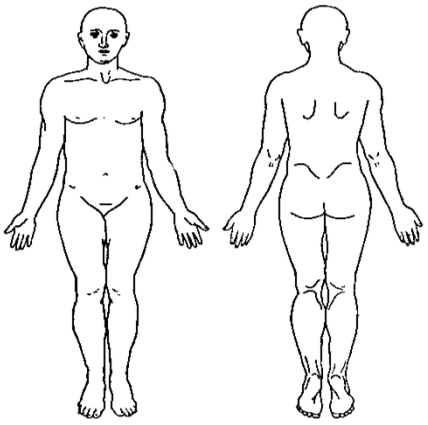
Has this condition occurred before? Yes/No

When did this condition begin? _____

Is the condition: ☐ Job-related ☐ Auto-related
☐ Fall ☐ Home Injury ☐Other: _____

Date of Accident: _____

What happened? _____



Please mark on the diagram the area of your discomfort and any radiation of pain.

Circle the grade to indicate the severity of your pain:

LEAST 0 1 2 3 4 5 6 7 8 9 10 WORST

Have you gone for any x-rays, ultrasounds, MRI's etc. for ***this injury/problem?*** YES / NO

If YES, where? _____and approximately when? _____

Surgeries/Major Injuries (Nature/Date): _____

Presence of internal pins, wires, artificial joints, special equipment, etc._____

What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking
☐ Lying Down ☐ Cold ☐ Dampness ☐ Other: _____

What relieves your condition? ☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐Medication
☐ Other: _____

Is it getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better

Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb
☐ Burning ☐ Intermittent ☐ Constant

Does the pain radiate anywhere? ☐ No ☐Arm (L or R) ☐Leg (L or R) ☐ Other: _____

When does it hurt? ☐Morning ☐Evening ☐wakes me up at night ☐Other: _____

Please describe how it feels when this problem is at its worse:_____

How did you hear about Binbrook Chiropractic & Physiotherapy?☐ Referral from Doctor ☐ Friend/Patient ☐ Sign ☐ Flyer/Advertisement ☐ Other: _____

CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.
Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercises.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related issues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.
The risks include:

- **Temporary worsening of symptoms:** - Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn, may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may not have symptoms. They may now know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while. Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.
  The consequence of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most sever cases, patient symptoms may include impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- **Stroke** – Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over time through aging or disease, or as the result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel to the brain where it can interrupt blood flow and cause a stroke.
  Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.
  Chiropractic treatment has also been associated with stroke. However, that association occurs very infrequently and may be explained because an artery was already damaged and the patient was progressing toward a stroke when the patient consulted the chiropractor. Present medical and scientific evidence does not establish that chiropractic treatment causes either damage to an artery or stroke.
  The consequences of a stroke can be very serious, including significant impairment of vision, speech, balance, and brain function, as well as paralysis or death.
- **Alternatives** – Alternatives to chiropractic treatment may include consulting with other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.
- **Questions or Concerns** – You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for you care. Inform you chiropractor immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR.

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment as well as the alternatives to treatment. I hereby consent to the chiropractic treatment as proposed to me.

_____
Name (Please Print)

_____
Signature of patient (or legal guardian) Date:_____ 20____

_____ Date:_____ 20____
Signature of Chiropractor

PRIVACY POLICY
PATIENT DISCLOSURE FORM: FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of providing you with quality Physiotherapy care. We understand the importance of protecting your personal information, and are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

In this office, Harnek Gill acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.
Attached to this consent form, we have outlined what your office is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols;
- Our privacy protocols comply with privacy legislation, standards or our regulatory body, the College of Physiotherapists of Ontario, and the law

Do not hesitate to discuss our policies with any member of our office staff. Please be assured that every staff person in our office is committed to ensure that you receive the best quality care.

PRIVACY POLICY
How Our Office Collects, Uses and Discloses Patients' Personal Information

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing your information.
This office will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient patient care;
- To identify and to ensure continuous high-quality service;
- To assess your health needs;
- To provide health care;
- To advise your treatment options;
- To enable us to contact you;
- To establish and maintain communication with you;
- To communicate with other treating health-care providers;
- To allow us to efficiently follow-up treatment and care;

- For teaching and demonstrating purposes on an anonymous basis;
- To complete and submit claims for third party adjudication and payment;
- To comply with legal and regulatory requirements, including the delivery of patients' charts and records to the College of Physiotherapists of Ontario in a timely fashion, when required, according to the provisions of the Regulated Health Professionals Act;
- To prepare materials for the Health Profession Appeal and Review Board (HPARB);
- To invoice for goods and services;

- To process credit card payments;
- To comply generally with the law;

By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information; we will seek your approval in advance.
Your information may be accessed by the regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purpose of the College of Physiotherapists fulfilling its mandate under the RHPA, and for the defense of a legal issue.
Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of request made, we will forward the information directly to you for review, and for your specific consent.
When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.
You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and that process.

PATIENT CONSENT

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information.
I agree that Binbrook Chiropractic & Physiotherapy can collect, use and disclose personal information about me as set out above in the information for Binbrook Chiropractic & Physiotherapy .

_____ _____

Signature Print Name

_____

Date