Optimum Performance Centre
Dr. Don Thrush

CONFIDENTIAL Patient Information **Date: _____AHC#: _____**

GENERAL INFORMATION

Name: _____ ☐ **Male** ☐ **Female** **Birth Date: M/_____ D/_____Y/_____**

Address: _____**City:** _____**Postal Code:** _____

Home Phone: _____ **Cell:** _____ **E-mail:** _____

Marital Status: _____ **Number of Children:** _____ **Spouse/Parent:** _____

Occupation: _____ **Employer:** _____ **Phone**: _____

Contact Person: _____ **Phone:** _____ **Relationship**: _____

W.C.B. Claim: ☐ **Yes** ☐ **No** **Motor Vehicle Accident**: ☐ **Yes** ☐ **No**

How did you hear about us?: _____

PRESENT COMPLAINT

Reason for Appointment: _____

Area(s) of Complaint: ☐ Neck ☐ Shoulder ☐ Mid back ☐ Low back
☐ Hips ☐ Other: _____

Date Symptoms Appeared: _____ **Onset:** ☐ Gradual ☐ Suddenly

Description: ☐ Sharp ☐ Shooting ☐ Stabbing ☐ Burning ☐ Numbness
☐ Achy ☐ Dull ☐ Deep ☐ Other:_____

Intensity: ☐ Mild ☐ Moderate ☐ Severe **Timing:** ☐ Comes and goes ☐ Constant

When is Pain Worst?: ☐ AM ☐ PM ☐ No Change

Aggravating Factors: ☐ Stress ☐ Activity ☐ Lifting ☐ Bending ☐ Standing ☐ Sitting
☐ Work ☐ Sleeping ☐ Other: _____

Relief From: ☐ Adjustment ☐ Massage ☐ Rest ☐ Ice ☐ Heat
☐ Lying ☐ Standing ☐ Sitting ☐ Medication ☐ Nothing

Interferes With: ☐ Sleep ☐ Work ☐ Quality of Life ☐ Other: _____

Recurring or Past Problem: ☐ Yes ☐ No **Last Occurrence:** _____

Doctors Seen for Condition: ☐ Chiropractor ☐ MD ☐ Orthopaedic Surgeon ☐ Neurologist
☐ Other: _____

Doctor's Name: _____ **Diagnosis:** _____ **X-rays:** ☐ Yes ☐ No

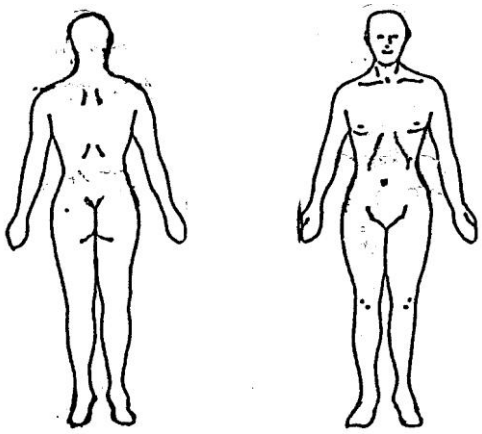
Treatment: _____ **Physiotherapy / Muscle Therapy:** ☐ Yes ☐ No

Treatment Results / Effectiveness: ☐ Good ☐ Fair ☐ Poor ☐ Unsure

Other Complaints: _____

Please indicate the location and type of pain you're currently experiencing:

Aching: *aaaaaa*
Sharp: ^^^^^
Burning: *xxxxx*
Shooting: +++++
Stabbing: *////////*
Numbness: *nnnnn*
Spasm: *oooooo*



MEDICAL HISTORY

It is important to your Doctor of Chiropractic that you provide a complete health history so that you can receive the best care possible.

Family Doctor: _____ **Clinic:** _____
Date of Last Visit: _____ **Purpose:** _____
Date of Last Physical Exam: _____ **Purpose:** _____
Medication (over the counter or prescription) and Nutritional Supplements:

_____

Previous Accidents or Injuries (car, falls, sports, etc.):

_____

Broken Bones: ☐ Yes ☐ No **What / When:**_____
Major Illnesses: _____**Major Operations:** _____

Please indicate any conditions or symptoms that you have had in the past (p) or are currently (c) experiencing:

__ Low Back Pain
__ Mid Back Pain
__ Neck Pain
__ Jaw Pain
__ Joint Stiffness
__ Spinal Curvatures
__ Sciatica
__ Poor Posture
__ Arthritis
__ Fibromyalgia
__ Bursitis
__ Muscle Cramps
__ Foot Problems
__ Swollen Joints / Ankles
__ High / Low Blood Pressure
__ Heart Disease
__ Chest Pain
__ Rapid / Slow Heartbeat
__ Poor Circulation
__ Stroke
__ Dizziness / Fainting

__ Headache / Migraines
__ Seizures
__ Polio
__ Anemia
__ Unexplained Weakness
__ Ear Noises / Ringing
__ Deafness / Difficulty Hearing
__ Eye Pain / Visual Problems
__ Enlarged / Painful Glands
__ Difficulty Swallowing
__ Nose Bleeds
__ Sinus Infections
__ Colds
__ Aids / HIV
__ Pneumonia
__ Persistent Cough
__ Asthma
__ Difficulty Breathing
__ Tuberculosis
__ Pleurisy
__ Nausea / Vomiting

__ Bruise Easily
__ Digestive Problems
__ Ulcers
__ Diarrhea
__ Colon Trouble
__ Hemorrhoids
__ Gall Bladder Trouble
__ Liver Disease
__ Hernia
__ Prostate Trouble
__ Frequent Urination
__ Bedwetting
__ Kidney Infections
__ Bladder Infections
__ Painful Urination
__ Venereal Diseases
__ Diabetes
__ Hypoglycemia
__ Thyroid Problems
__ Fatigue
__ Loss of Sleep

__ Night Sweats
__ Cancer
__ Allergy
__ Hay Fever
__ Alcoholism
__ Nervousness
__ Depression
__ Anxiety
__ Itching
__ Rashes

Females:
__ Heavy / Light Menstrual Flow
__ Irregular Cycle
__ Hot Flashes
__ Breast Lumps
__ PMS
__ Cramps
__ Birth Control

Pregnant:
☐ Yes ☐ No ☐ Unsure

Tingling or Numbness: __ Shoulders __ Hips __ Arms __ Legs __ Hands __ Feet

CHIROPRACTIC HISTORY

Past Chiropractic Care: ☐ Yes ☐ No **Reason:** _____**X-rays:** ☐ Yes ☐ No
Chiropractor: _____ **Date of Last Visit:** _____
Technique: ☐ Manual (By Hand) ☐ Instrument (Activator, etc.) ☐ Other: _____ ☐ Unsure
Results: ☐ Good ☐ Fair ☐ Poor ☐ Unsure
Other Comments: _____

FAMILY MEDICAL HISTORY

Family Medical History: (Include parents (M, F), children (C), sibling (S), grandparents (GM, GF))
__ High Blood Pressure __ Stroke __ Cancer __ Arthritis
__ Heart Disease __ Diabetes __ Genetic Disease / Specify: _____
__ Other: _____

Habits:	Heavy	Moderate	Light	None
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Exercise	☐	☐	☐	☐

Type/Frequency: _____

Sleep: Hours: _____
☐ Light ☐ Deep ☐ Restless
☐ Side ☐ Back ☐ Stomach

Stress:
Home: ☐ High ☐ Medium ☐ Low
Work/School: ☐ High ☐ Medium ☐ Low

Foot Support:
☐ Heel Lift
☐ Arch Supports
☐ Orthotics
☐ Other: _____

WAIVER

PAYMENT IS EXPECTED AT TIME OF VISIT

Person responsible for payment _____

I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered will be immediately due and payable.

I understand that chiropractic does not treat disease or symptoms but uses them to ascertain where the specific adjustment(s) is / are needed. Chiropractic only attempts to adjust vertebrae, restoring the nerve impulse to the involved tissue, thus allowing the body its best chance of healing itself. I give the doctors and assistants at Optimum Performance Centre full permission to render care to myself and / or my family.

Patient's Signature_____ **Date**_____

Signature of Guardian Authorizing Care_____ **Date**_____