Harbourfront
Health & Wellness Centre
Life in Balance

CHIROPRACTIC / PHYSIOTHERAPY PRIVATE PATIENT ASSESSMENT FORM

PERSONAL INFORMATION

Name: ______________________________ **Today's Date:** ______________________

Date of Birth: ________________________ **Gender:** Male ☐ Female ☐
Address: ____
Home Phone: ________________________ **Work Phone:** ______________________
Cell Phone: __________________________ Email address: _____________________
Employer: ____________________________ Occupation: _______________________
Work Status: Student ☐ Employed ☐ Work at Home ☐ Retired ☐
Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐
Number of Children: ___________________ Ages: ____________________________
Emergency Contact: _________________ **Phone:** ___________________________
(relationship) ___________________

Injury description: ____
Referred by: ____

Please Note the Following:

- **PAYMENT:** **Fees for chiropractic and physiotherapy services are due at EACH visit.**
- **EXTENDED HEALTH INFORMATION**
  Do you (or your spouse) have extended health coverage through work? Yes ☐ No ☐
  Please be advised that Harbourfront Rehab does not bill extended health plans directly.
  You will need to submit your invoices to receive re-imbursement for chiropractic and physiotherapy services.
  We encourage you to communicate directly with your carrier to learn more about your coverage. Understanding the details/limitations of your coverage is the patients responsibility.
- **REHAB FILES:** Patients' files may be shared within the clinic between the chiropractor and physiotherapist when cross referrals occur.
- **NO SHOW FEES/SAME DAY CANCELLATIONS: As a courtesy to other patients, we do require at least 24hrs notice to change or cancel appointments. Failure to do so can result in no show fees.**

I have read and understand the above information: X ______________________________
Patient Signature

Medical and Past Health Questionnaire

Name: ______________________________ Date: ____________________

Instructions: Please complete the following questionnaire. You may use the opposite side of the page if you require more space or wish to include additional comments.

1. Do you presently or have you ever suffered from any of the following illnesses?

Illness	Yes	No	If yes, please provide date/details	Illness	Yes	No	If yes, please provide date/details
Diabetes				Arthritis			
Heart Disease/ Attack / Angina				AIDS or HIV			
Cancer				Liver Disease			
Stroke				TMJ Syndrome			
High Blood Pressure				Asthma			
Thyroid Disease				Other:			

2. Have you ever undergone any of the following surgeries?

Surgery	Yes	No	If yes, please provide date/details
Back/Spine			
Hernia			
Other:			
Other:			

3. Have you had any past fractures?

Bone	Yes	No	Date/Details	Bone	Yes	No	Date/Details
Skull				Pelvis			
Vertebrae				Leg / Foot			
Ribs				Arm / Hand			
Other:							

4. Other

Are you taking any medications? ☐ Yes ☐ No Please specify:____________________
____

Do any past health problems continue to affect your function? (ie, walk, dress, work)
☐ Yes ☐ No Please specify:______________________________
____

Are you pregnant? ☐ Yes ☐ No How many months? ____________
Do you smoke? ☐ Yes ☐ No *How many/day?*____________
Do you drink alcohol? ☐ Yes ☐ No How many/week? ____________

Patient Signature: ______________________________ **Date:**____________

RANSFORD PAIN DIAGRAM

On the drawings below, please indicate where you are experiencing pain by drawing in the letter abbreviation on the diagrams that most accurately reflect the type of discomfort that you have been experiencing.

Numbness = N	Tingling = T	Dull Pain = D
Sharp Pain = P	Burning = B	Stiffness = S