GLENWOOD SPORT & SPINE

DATE: _____

NAME: _____ Male / Female DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____
POSTAL CODE: _____ PHONE #: (h) _____
(w) _____
E-mail address: _____ (c) _____
(optional - for clinic communications)

Medical Doctor: _____ Health Care #: _____

How did you hear of our clinic?
__ from another patient: _____ (name)
__ google (internet) search
__ from my medical doctor
__ walked/drove by
__ other: _____

Marital Status: _____ Occupation: _____
Work / Private Health Insurance: _____
Emergency Contact: _____ Phone Number: _____

Is the reason you came to this office related to a –

A) ***RECENT*** Motor Vehicle Accident?	YES	NO
B) ***CURRENT*** Work-related injury? (WCB)	YES	NO

CHIROPRACTIC:	
Regular Treatment	$75
Re-Assessment	$85
Age 75+	bill insurance only
Assessment	$100

SHOCKWAVE THERAPY:	$90
CUSTOM ORTHOTICS:	$500
COMPRESSION STOCKINGS:	$150-$200

PHYSIOTHERAPY:	
Regular Treatment	$100
Extended Treatment	$150
Assessment	$150
Pelvic Floor Treatment	$135
Pelvic Ext Treatment	$175
Pelvic Floor Assessment	$175

MASSAGE:	
30 minutes	$65
45 minutes	$90
60 minutes	$110
60 minutes HOT STONE	$130
90 minutes	$150
90 minutes HOT STONE	$170

ACUPUNCTURE:	
Acu/IMS 30 min	$100
Acu/IMS 60 min	$130
Cupping & Tuina 30 min	$100
Cupping & Tuina 60 min	$130
Age 75+	bill insurance only
Assessment	$130

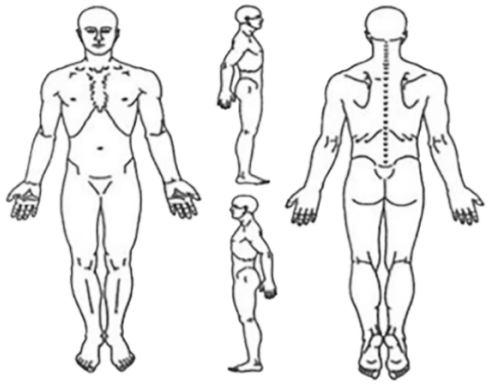
PSYCHOTHERAPY:	
Regular Session	$155
Couples Session	$155
Family Session	$225

Unless prior arrangements have been made, services must be paid for at the time they are provided. Fees are subject to change.
CANCELLATION NOTICE – 8 hr. notice is required for ALL appointments, NO SHOWS will be charged the regular fee.
Acceptance of this form gives Glenwood Sport & Spine consent to obtain insurance coverage information on your behalf.

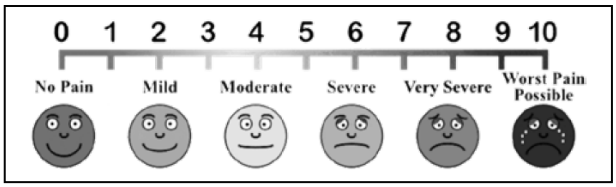
SPINE DISABILITY INDEX (OSWESTRY)

1. MARK WHAT YOU ARE FEELING ON THE DIAGRAM

ACHE Aa | PINS & NEEDLES pp | BURNING bb | STABBING ss



2. CIRCLE THE NUMBER WHICH DESCRIBES YOUR PAIN



3. ANSWER THE FOLLOWING QUESTIONS

SECTION 1 – Pain Intensity

0 No pain / doesn't apply
1 Mild pain
2 Moderate pain
3 Severe pain
4 Worst possible pain

SECTION 2 – Personal Care (washing, dressing, etc.)

0 No pain; no restrictions / doesn't apply
1 Mild pain; no restrictions
2 Moderate pain; need to go slowly
3 Moderate pain; need some assistance
4 Severe pain; need 100% assistance

SECTION 3 – Lifting

0 No pain with heavy weight / doesn't apply
1 Increased pain with heavy weight
2 Increased pain with moderate weight
3 Increased pain with light weight
4 Increased pain with any weight

SECTION 4 – Walking

0 No pain; any distance / doesn't apply
1 Increased pain after 20 minutes
2 Increased pain after 10 minutes
3 Increased pain after 5 minutes
4 Increased pain with any walking

SECTION 5 – Sitting

0 No pain after several hours / doesn't apply
1 Increased pain after several hours
2 Increased pain after 1 hour
3 Increased pain after ½ hour
4 Increased pain with any sitting

SECTION 6 – Standing

0 No pain after several hours / doesn't apply
1 Increased pain after several hours
2 Increased pain after 1 hour
3 Increased pain after ½ hour
4 Increased pain with any standing

SECTION 7 – Sleeping

0 Perfect sleep / doesn't apply
1 Mildly disturbed sleep
2 Moderately disturbed sleep
3 Greatly disturbed sleep
4 Totally disturbed sleep

SECTION 8 – Work

0 Can do usual plus extra work / doesn't apply
1 Can do usual work; no extra work
2 Can do 50% of usual work
3 Can do 25% of usual work
4 Cannot work

SECTION 9 – Recreation

0 Can do all activities / doesn't apply
1 Can do most activities
2 Can do some activities
3 Can do a few activities
4 Cannot do any activities

SECTION 10 – Travelling

0 No pain on long trips / doesn't apply
1 Mild pain on long trips
2 Moderate pain on long trips
3 Moderate pain on short trips
4 Severe pain on short trips

Name: _____ Date: _____

/40

Confidential Case History

Patient Name: _____ Date: _____

Reason for your visit: _____

How did your symptoms start? _____

How long has it been happening? _____

Has it happened before? _____

How often do you experience your symptoms?

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day)

Does your pain radiate down your arms or legs? _____

How are your symptoms changing?

☐ Getting better ☐ Not changing ☐ Getting worse

		no pain										unbearable
How bad are your symptoms at their:	worst:	0	1	2	3	4	5	6	7	8	9	10
	best:	0	1	2	3	4	5	6	7	8	9	10

What makes your symptoms worse? _____ better? _____

Have you had previous treatment?

☐ No one ☐ Chiropractic ☐ Physiotherapy
☐ Acupuncture ☐ Massage Therapy ☐ Medical Doctor

What tests have you had for your symptoms and when were they performed?

X-Rays date: _____ Ultrasound date: _____ CT Scan date: _____ MRI date: _____

Is there a family history of this issue? _____

Are there any other issues you want to discuss? _____

List all prescription, medications, supplements you are taking:

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

List any relevant surgical procedures you've had:

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Systems Review

Circle any conditions that are presently causing you a problem.

Underline those that have caused you problems in the past.

GENERAL SYMPTOMS	RESPIRATORY	GENITOURINARY
Fever	Chronic cough	Frequent urination
Sweats	Spitting up phlegm	Painful urination
Fainting	Spitting up blood	Blood in urine
Sleep disturbance	Chest pain	Pus in urine
Fatigue	Wheezing	Kidney infection
Nervousness	Difficulty breathing	Prostate trouble
Weight loss	Asthma	Uncontrollable urine flow
Weight gain		
NEUROLOGICAL	**CARDIOVASCULAR**	**GASTROINTESTINAL**
Visual disturbance	Rapid beating heart	Poor appetite
Dizziness	Slow beating heart	Difficult digestion
Fainting	High blood pressure	Heartburn
Convulsions	Low blood pressure	Ulcers
Headache	Pain over heart	Nausea
Numbness	Hardening of arteries	Vomiting
Neuralgia (nerve pain)	Swollen ankles	Constipation
Poor coordination	Poor circulation	Diarrhea
Weakness	Palpitations	Blood in stool
	Cold hand or feet	Gallbladder/jaundice
	Varicose veins	Colitis
EYES, EARS, NOSE, THROAT	**MUSCLE & JOINT**	**FOR WOMEN ONLY**
Eye pain	Neck pain	Painful menstruation
Double vision	Low back pain	Hot flashes
Ringing in ears	Arm pain	Irregular cycle
Deafness	Shoulder pain	Cramps or back pain
Nosebleeds	Leg pain	Vaginal discharge
Trouble swallowing	Knee pain	Nipple discharge
Hoarseness	Foot pain	Lumps in breast
Sinus infection	Pain/numbness down arms or legs	Menopausal symptoms
Nasal drainage	Pain between shoulders swollen joints	Birth control pills
Enlarged glands	Spinal curvature	Miscarriages
	Arthritis	Complications with pregnancy
	Fractures	Pregnant? Y / N Week?
		Other: