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: _____

Would you prefer appointment reminders via: ☐ phone ☐ text ☐ email

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

FEE SCHEDULE

CHIROPRACTIC:

Regular Treatment	$70
Re-Assessment	$80
Assessment	$100
Age 75+	we bill insurance only, no co-payment from patient

MASSAGE:

30 minutes	$60		
45 minutes	$80		
60 minutes	$100	60 minutes HOT STONE	$125
90 minutes	$130	90 minutes HOT STONE	$155

ACUPUNCTURE:

Assessment	$130				
Acu/IMS 60 min	$130	Cupping & Tuina 60 min	$130	Stretch Therapy 60 min	$130
Acu/IMS 30 min	$100	Cupping & Tuina 30 min	$100	Stretch Therapy 30 min	$100

CUSTOM ORTHOTICS: $500
COMPRESSION STOCKINGS: varies

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.

Confidential Case History

Patient Name: _____ Date: _____

Reason for your visit: _____
Any other complaints? _____

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

How bad are your symptoms at their:		no pain										unbearable
	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: _____ MRI date: _____ CT Scan date: _____ Other date: _____

List all prescription and over-the-counter medications you are taking:

_____ _____ _____

List any relevant surgical procedures you've had:

_____ _____ _____

For each of the conditions listed below, place a check in the box if it applies to you:

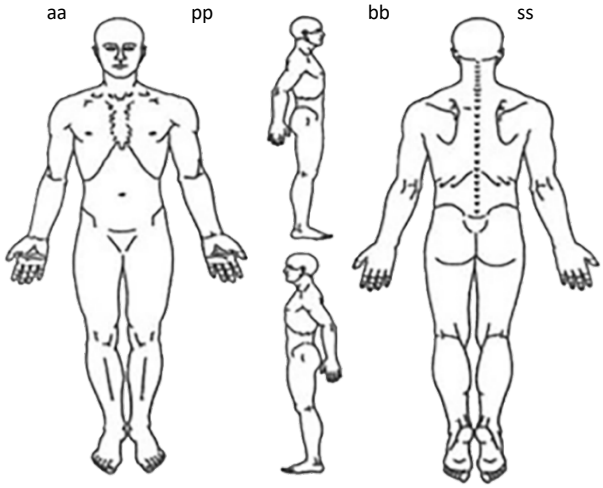
Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	Jaw Pain	☐	☐	Fatigue
☐	☐	Neck Pain	☐	☐	Joint Swelling/Stiffness	☐	☐	Muscular In-coordination
☐	☐	Mid Back Pain	☐	☐	Arthritis	☐	☐	Visual Disturbances
☐	☐	Low Back Pain	☐	☐	Swelling	☐	☐	Dizziness
						☐	☐	Nausea
☐	☐	Shoulder Pain	☐	☐	High Blood Pressure			
☐	☐	Elbow/Upper Arm Pain	☐	☐	Heart Attack	☐	☐	Constipation / Diarrhea
☐	☐	Wrist Pain	☐	☐	Chest Pains	☐	☐	Weight Gain / Loss
						☐	☐	Fever / Chills / Night Sweats
☐	☐	Hip/Upper Leg Pain	☐	☐	Stroke	☐	☐	Night Pain
☐	☐	Knee/Lower Leg Pain	☐	☐	Cancer			
☐	☐	Ankle / Foot Pain	☐	☐	Diabetes			

Dr.___

1.

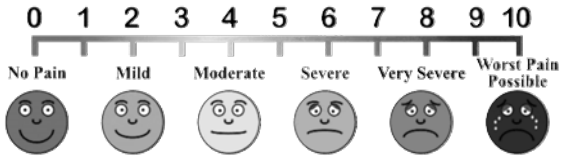
MARK WHAT YOU ARE FEELING ON THE DIAGRAM

ACHE aa PINS & NEEDLES pp BURNING bb STABBING ss



2.

Circle the number or range which best describes your pain:



3.

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

SPINE DISABILITY INDEX

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 unlimited 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

Patient Name: _____

Date: _____