

Confidential Client History Information

Name: _____ **Date:** _____ (mm/dd/yyyy)

Address _____ **City** _____ **Prov** _____ **Postal Code** _____

Phone(Cell) _____ **Phone(Home)** _____

Date of Birth: ____ (mm) ____ (dd) ____ (yyyy) **Age** ____ **Marital Status:** S M W D Sep (Circle one)

Email: _____ **Would you like email appointment reminders Y / N**

Occupation _____ **Employer** _____

Spouses Name: _____ **# of Children** _____

Please Tell us who referred you: _____, or how you heard about the office:

Reason for your visit: What is your Main complaint _____

When did it start? _____ **Have you experienced this before?** _____

Is this condition interfering with your **Work Sleep Daily Routine Exercise Other**

Do you Experience pain? if so what is the character of your pain

☐ Sharp ☐ Dull Ache ☐ Burning ☐ Throbbing ☐ Numbness ☐ Stiffness ☐ Cramping ☐ Pressure

Is it getting: ☐ Worse ☐ Staying the same ☐ Better ☐ Constant ☐ Comes and Goes ☐ Radiating Please

circle the severity of your pain: least - 0 1 2 3 4 5 6 7 8 9 10 - worst

Do you have any secondary complaints _____

What are your Goals? (Check all that apply)

☐ **Mobility and Functional fitness**

☐ **Injury Prevention**

☐ **Chronic Pain Management**

☐ **improving Balance and Coordination**

☐ **Improving Flexibility**

☐ **Reducing Muscle Tension and Stiffness**

☐ **Manage a Chronic Health Condition**

☐ **Return to Work**

☐ **Return to Sport**

☐ **Increase Functional Abilities for Daily Life**

☐ **Enhance Recovery after surgery/injury**

☐ **Improve health and wellness**

Family Health History

Many health problems are the result of hereditary factors. Information about your family members will give us a better understanding of your total health picture.

Name	Relationship	Past and Present Health Problems

Lifestyle Factors – Please check the appropriate box

	None	Light	Moderate	Heavy
Exercise				
Sleep				
Stress				
Tobacco				
Alcohol				
Caffeine				
Junk food				

Health Screening and Testing

Test	Date	Of what region	Results
X-rays			
Cat Scan			
MRI			
Bone Density			

Medications

Reason	Name	Reason	Name
Pain Relief		Diabetes	
Anti-inflammatory		Thyroid	
Muscle relaxant		Other	
Blood pressure			
Blood thinner			
Heart			
Cholesterol			

Supplements

Surgical History

Surgery	Date	Surgery	Date
Hip replacement L R		Bowel	
Knee replacement L R		Thyroid	
Spinal surgery		Gallbladder	
Fractures(surgical repair)		C-section	
Shoulder L R		Hysterectomy	
Knee L R		Other	
Carpal tunnel L R			
Heart			

CONFIDENTIAL HEALTH REPORT

Patient Name: _____

Please circle any conditions presently causing you problems. Please check (X) any conditions that were a problem in the past.

General Symptoms

Headache/Migraine
Fever
Sweats/Chills
Fainting
Dizziness/vertigo
Loss of sleep
Tremors/seizures
Anxiety/depression
Mood swings
Memory changes
Difficulty concentrating
Numbness/weakness
Pins and needles
Fatigue
Neuralgia (nerve pain)
Loss of balance

Muscles and Joints

Osteoarthritis
Arthritis _____ (type)
Osteoporosis
Red or swollen joints
Bursitis/Tendonitis
Low back pain
Sciatica
Neck pain or stiffness
Pain between shoulders
Pain and numbness in:
Shoulders/arms
Elbows/hands
Hips/legs
Knees/feet
Painful tail bone
Poor posture
Spinal curvature
Jaw pain/clicking
Fibromyalgia
Multiple sclerosis
Parkinson's

E.E.N.T.

Vision changes
Eye pain
Deafness/hearing aids
Frequent colds
Sinus/ear infections
Enlarged glands
Tinnitus (ringing ears)
Nose bleeds
Thyroid

Skin

Rashes/itching
Bruise easily
Dryness
Eczema/Psoriasis

Respiratory

Chronic cough
Spitting up blood
Chest pain
Shortness of breath
Snoring
Sleep apnea
Asthma
Pneumonia
Tuberculosis

Cardiovascular

Rapid/irregular heartbeat
Pacemaker
High blood pressure
Low blood pressure
Angina
Heart attack
Stroke/TIA
High cholesterol
Poor circulation
Varicose veins
Swollen ankles
Blood clotting/bleeding disorder

Genitourinary

Difficulty with/frequent urination
Blood in urine
Kidney infection/stones
Prostate problems

For Women Only

Painful menstruation/cramping
Menopause symptoms
Irregular cycle
Pregnant Yes ☐ No ☐
Post-menopausal

Gastrointestinal

Diabetes
Low blood sugar
Anemia
Poor appetite
Indigestion/heartburn
Excessive thirst
Bloating/gas
Nausea/vomiting
Abdominal pain
Ulcers
Constipation/Diarrhea
Colitis/Irritable bowel
Jaundice/Hepatitis A B C
Gall bladder

Cancer:

Allergies

Environmental: _____

Food: _____

Drug: _____

Latex Yes ☐ No ☐

Dr. Jeff Kinnersly

Dr. Melissa Mullett

Mikayla Ransberry R.Kin

Uxbridge Chiropractic Centre

CONSENT TO REGISTERED KINESIOLOGIST CARE

It is important to understand the benefits, risks, and alternatives before participating in kinesiology services. I voluntarily consent to assessment and care provided by a Registered Kinesiologist (R.Kin.).

Services May Include

- Physical and movement assessments
- Exercise prescription and supervised exercise
- Strength, mobility, balance, flexibility, and functional training
- Corrective exercise and exercise therapy
- Education regarding physical activity and healthy movement
- Manual cueing and hands-on guidance where appropriate

Assessment and Treatment

I understand that assessment may include questions regarding my medical history, injuries, medications, lifestyle, and physical activity, as well as measurements of blood pressure, heart rate, mobility, flexibility, strength, balance, posture, and movement.

I understand that kinesiology services may involve physical activity, exercise, stretching, and hands-on guidance. Potential risks include muscle soreness, stiffness, strains, joint irritation, aggravation of existing conditions, dizziness, falls, or other injury. Rarely, serious medical events may occur.

I am responsible for informing the Registered Kinesiologist of any medical conditions, injuries, surgeries, medications, allergies, physical limitations, or other concerns that may affect participation. I agree to report any pain, dizziness, numbness, tingling, unusual symptoms, or discomfort during or after treatment.

I understand that participation is voluntary and I may refuse, modify, or stop any activity at any time. I may request that hands-on contact be stopped. The Registered Kinesiologist may modify or discontinue treatment if they believe it is unsafe to continue. No specific outcome or improvement is guaranteed.

Emergency Events

In the event of an emergency, I authorize the Registered Kinesiologist and/or facility staff to obtain emergency medical assistance when necessary.

I confirm that I have provided accurate and complete information, have had the opportunity to ask questions, and understand the nature, benefits, risks, and alternatives of the services provided.

By signing below, I confirm that I have read, understood, and voluntarily consent to Registered Kinesiologist care.

Patient Name (Print): _____

Patient/Guardian Signature: _____

Date: _____

Registered Kinesiologist Signature: _____

CONSENT TO AUDIO RECORDING FOR CLINICAL DOCUMENTATION

I understand that, with my consent, conversations or portions of my appointments with the Registered Kinesiologist may be audio recorded for the purpose of accurate clinical documentation and charting.

I understand that:

- Audio recordings will be used only to assist with clinical documentation and will not be used for marketing, teaching, or other purposes without additional consent.
- Recordings and the resulting documentation will be treated as confidential and handled in accordance with applicable privacy legislation, including the Personal Health Information Protection Act, 2004 (PHIPA), where applicable.
- Recordings will be securely stored and accessed only by authorized individuals involved in providing or documenting my care.
- I may ask questions about the recording process and may request that recording be stopped at any time.
- I may withdraw my consent to future recordings at any time. Withdrawing consent will not affect my ability to receive kinesiology services.
- I understand that recording is optional and that I may choose not to have my conversations recorded.

By signing below, I confirm that I have read and understood the above information and voluntarily consent to audio recording for the purpose of clinical documentation.

Patient Name (Print): _____

Patient/Guardian Signature: _____

Date: _____

Registered Kinesiologist Signature: _____

Dr. Jeff Kinnersly - Chiropractor

Dr. Melissa Mullett - Chiropractor

Dr. Kendra Clifford - Naturopath

Mikayla Ransberry Registered Kinesiologist

Patient Consent for Collection, Use and Disclosure of Personal Information

Privacy and protecting your personal information is an important part and consideration at the Uxbridge Chiropractic Centre. This privacy policy outlines what we do to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Collection, use, storage, and destruction of your personal information complies with existing legislation, privacy protection protocols, and the standards of our regulatory bodies, The College of Chiropractors of Ontario and The College of Naturopaths of Ontario.

We are committed to collecting, using and disclosing your information responsibly and do so for the following purposes:

- To establish your health concerns, provide health care and advise you of your treatment options; To establish and maintain contact with you to book and confirm appointments and distribute health care information;
- To efficiently follow up with you for treatment, care and billing;
- To communicate with other treating health-care providers;
- To provide health information for insurance claim purposes
- To authorize electronic transmission and/or assign claim payments to provider for insurance claims processing
- To invoice for goods and services, and process credit card, debit and cheque payments;
- To enable us to contact you (including marketing purposes), by telephone, fax, e-mail and instant messaging and regular mail;
- To comply with all regulatory and legal requirements including court orders, statutory requirements to advise authorities of child abuse, reportable diseases and individuals who may be an imminent threat to harm themselves or others

Patient Consent

I _____, have reviewed the above information that explains how Uxbridge Chiropractic Centre will use my personal information and the steps that are taken to protect my information.

Patient/Guardian Signature: _____

Date: _____

Registered Kinesiologist Signature: _____