ATLAS SPORTS FITNESS AND REHAB
Dr. Parminder S. Bhalesar
Doctor of Chiropractic
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CONFIDENTIAL PATIENT INFORMATION SHEET

Patient No:_____
Office Use Only

*Please complete **FULLY** and accurately*

PERSONAL HISTORY

Name:_____ Date:_____

Address: _____ City, Province: _____ Postal Code: _____

Telephone: _____ Cell: _____ Date of Birth: D____M____Y_____

Sex: Male_____ Female_____ Occupation:_____ Marital Status: S M D W (Circle)

Family Doctor (Name and Telephone): _____

Emergency Contact (Name, Telephone, Relationship): _____

How did you hear about our office? _____

Is this a work injury? Y N (Circle) Is this a motor vehicle accident case? Y N (Circle)

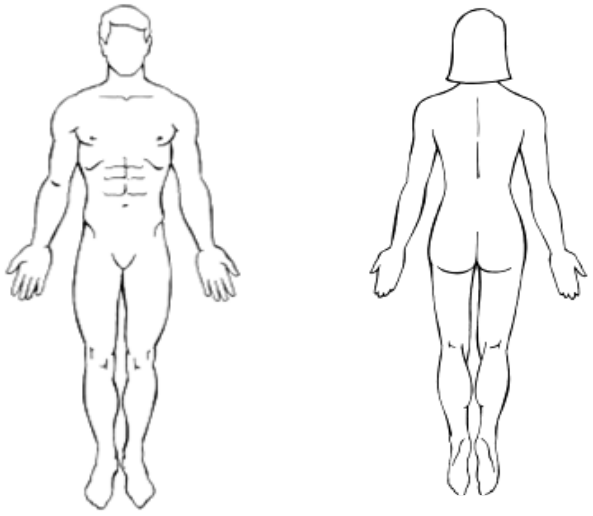
CURRENT HEALTH HISTORY

Current Complaints in order of importance to you: 1) _____

2) _____

3) _____

On the drawing to the right mark all painful areas with **X**



Describe Pain: _____ Sharp/stabbing _____ Pins/needles

_____ Numbness _____ Burning

_____ Dull ache _____Stiff/tight

How long have you had this current problem? _____

Have you had it before? _____

Have you been treated for this condition before? _____

Rate your pain 0 (no pain) to 10 (worst pain)_____

Rate you stress level 0 (low) to (high) _____

Do you exercise regularly, if so describe type, frequency, duration?_____

_____

List any medications, supplements and natural herbs you are currently taking:_____

_____

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Do you wear Orthotics? Y N (Circle) If yes, how long have you had them? _____
Do you Smoke? Y N (Circle) If yes, _____ cigarettes/day for _____years
Dietary satisfaction: _____ High _____ Medium _____ Low
Sleep Habits: _____ hours per night. Height: _____ Weight: _____

FAMILY HEALTH HISTORY

Have you or anyone in your family had the following (Specify whom):

- ❑ Heart disease _____
- ❑ Cancer _____
- ❑ Stroke _____
- ❑ High blood pressure _____
- ❑ Diabetes _____
- ❑ Other Diseases _____

PAST HEALTH HISTORY

List any previous **Surgeries** and the year(s) they occurred:
_____ Year _____ _____ Year _____
List any previous **Fractures** and the year(s) they occurred:
_____ Year _____ _____ Year _____
List any previous **Accident / traumas** and the year(s) they occurred
_____ Year _____ _____ Year _____

GENERAL HEALTH INFORMATION

Please check all that apply below if you have experienced it in **the past 6 months**

Head and neck: ___ Headaches ___ Neck pain ___ Hearing problems ___ Ringing in the ears
___ Sinusitis ___ Vertigo/Dizziness ___ Eye problems ___ Vision problems
___ Nose problems ___ TMJ (Jaw pain) ___ Sore throat ___Voice changes

Chest, lung, heart and skin: ___ Chest pain ___ Palpitations (heart) ___ Blood pressure problems
___ Allergies ___ Insomnia ___ Night Sweats ___ Lung problems
___ Shortness of breath ___ Asthma ___ Skin problems ___ Restlessness/irritability

Digestive system and miscellaneous: ___ Nausea/vomiting ___ Heartburn ___ Poor appetite ___ Loss of taste
___ Bloating ___Diarrhea ___Constipation ___ Abdominal pain ___ Gas, rumbling ___ Hemorrhoids
___ Frequent weight change

Liver and gall bladder: ___Liver problems ___ Sweaty palms ___Sweats easily ___ Irritated easily
___ Brittle nails ___ Bitter taste in mouth ___ Muscle cramps ___ Anxiety ___ Slow digestion
___ Tension headaches ___ Stiff joint/muscles ___ Restlessness

Kidney, urinary tract, endocrine system: ___ Kidney stones ___ Urinary bladder problems ___ Prostatitis
___ Kidney problems ___ Frequent urination ___ Urinary tract infections ___ Incontinence ___ Joint pain
___ Feeling cold/hot ___ Weak or sore knees ___ Low back pain ___ Low energy

Gynecological (for women only): ___ Painful periods ___ Heavy periods ___ Irregular periods ___ Hot flashes
___ Absent periods ___ Long periods ___ Endometriosis ___ Painful intercourse ___ Fertility problems
___ Pre-menstrual syndrome ___ Miscarriages/abortions ___ Breast Problems
Are you currently pregnant? Y N (Circle) If Yes, how many weeks? _____

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Informed Consent to Chiropractic Treatment:
There are risks and possible risks involved with manual therapy techniques used by Doctors of Chiropractic. In particular you should note:

While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures. There are reported cases of strokes associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and occurrence of stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with cervical adjustments is extremely remote.

There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustments, although no specific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment.

There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some Doctors of Chiropractic.

Informed Consent to Acupuncture Treatment:
I, the undersigned, hereby request and consent to the performance of acupuncture and other procedures related to Chinese medicine, as necessary, including moxibustion, cupping, , tuina massage, herbal medication and/or electro acupuncture by Sukhjit Dhinsa, DTCM. I understand and am informed that in the practice of acupuncture, there are some risks to treatments including fainting from nervousness, bruising, hunger, extreme tiredness, bent needles and post needling sensation. I understand that occasional upset stomach, diarrhea, insomnia and sweating may occur. I have been advised that only newly packaged, pre-sterilized needles will be used and disposed of properly immediately after each use in proper sharps disposing bins. I have been advised not to discontinue the use of my medications without consulting my family physician first.

Informed Consent to Physiotherapy Treatment:
I, the undersigned, do hereby agree and give my consent for Atlas Sports Fitness and Rehab, to provide me with medical care and treatment that is considered necessary and proper in diagnosing and /or treating my physical condition. I acknowledge I have discussed or had the opportunity to discuss with my doctors the nature and purpose of my specific treatment and the risks and benefits involved with such treatment.

Consent for Personal Information:
I understand that to provide me with chiropractic, acupuncture, and physiotherapy goods and services, Atlas Sports Fitness and Rehab. will collect some personal information about me (e.g. Telephone number, address, insurance coverage).

I have discussed the Privacy Policy about collection of information, steps taken to protect the information and my right to review my personal information. I understand how the privacy policy applies to me. I have been given a chance to ask questions which have been answered to my satisfaction. The information contained on this form is true to the best of my knowledge. My file is private and confidential and will only be discussed with me and/or my physician as medically necessary with my consent. If any matter of my file is to be disclosed to any other party, a written consent from me must be provided before **ANY** information is given.

All payments for treatments, supplies, orthotics, etc rendered at Atlas Sports Fitness and Rehab are due at the time of service unless prior arrangements have been made.
I acknowledge that I have read and discussed this consent with the appropriate treating practitioners at Atlas Sports Fitness and Rehab including costs involved, payment options, nature and treatment in general, treatment options and recommendations for a treatment program.

I intend this consent to apply to all present and future Chiropractic, Acupuncture and Physiotherapy.

Dated this _____day of _____, 20_____ in the City of Mississauga, Regional Municipality of Peel.

_____ _____
Patient Signature (Legal Guardian) Witness Signature

_____ _____