pure elevate your health

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Welcome to Pure. Please complete the following forms. Information collected is used to determine care required based on your current condition. After filling out these forms you will meet with one of our team members who will review your history with you. Based on your history, certain examinations will be performed including spinal images if necessary. Your case will then be reviewed by our team of practitioners and one of them will review your exam findings with you.

Please be prepared to spend about 60 minutes with us today.

CONFIDENTIAL PATIENT HISTORY

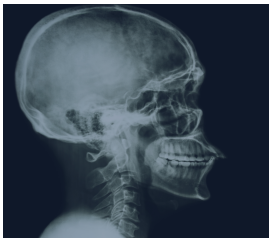
Name _____ Date _____
Address _____ City _____ Postal Code _____
Home Phone _____ Business Phone _____ Cellular/Other _____
Date of Birth _____ Email* _____ Sex ___ M ___ F Age _____
Occupation or Professions _____ Employer _____
Marital Status ___ Single ___ Married ___ Divorced ___ Common-Law Name of Spouse _____
Number of Children _____ Name and Ages of Children _____
Have you ever been to: ___ Chiropractor ___ Massage Therapist ___ Physiotherapist ___ Nutritionist
If yes to any of the above, what clinic? _____
Is this complaint a result of a work related injury? _____
How did you hear about Pure? _____
Name of Family Medical Doctor _____ Alberta Health Care Number _____
Emergency Contact Name _____ Emergency Contact Phone Number _____
*Your email will be used for email appointment reminders and office communication pertaining to your care.

There are many lifestyle stressors that can effect your health. Please answer the following questions regarding lifestyle stressors.

STRESS LEVELS

How would you rate your current mental health? Poor Unsatisfactory Satisfactory Good Very Good
How intense is your emotional distress ? (mild) 0 1 2 3 4 5 6 7 8 9 10 (severe)
How well do you cope with obstacles in relation to your ability to get along with others, perform at work/school, and perform day to day tasks? Poor Unsatisfactory Satisfactory Good Very Good
Please describe any significant or stressful life events that you have been experiencing ? _____

PRACTITIONER NOTES:



NERVE SUPPLY

What time of day is your energy levels the lowest? Morning Afternoon Evening
Any previous history of diagnosed or undiagnosed concussions? Y N
How many hours per day do you spend sitting? 0 1 2 3 4 5 6 7 8 9 10 11 12+ (hours)
Have you ever experienced balance problems, vertigo or dizziness? Y N

PRACTITIONER NOTES:

FUEL AND OXYGEN

Do you feel stressed around planning, organizing or prepping food for yourself or your family? Y N
Do you struggle with healthy food relationships? Y N
Do you feel that your current diet is meeting your or your family's nutritional needs? Y N

In the last 12 months:

Have you had any of the following behaviours: binging, purging, or restricting foods or specific groups of foods (ex: carbs)? Y N
Do you deal with gas, boating, pain, distention, and/or fluctuations in constipation/diarrhea? Y N
Have you ever been referred to a Registered Dietitian by a health care professional due to any of the following issues: chronic disease, pregnancy, picky eating, sports nutrition, disordered eating, or weight loss (or other reasons not mentioned)? Y N

PRACTITIONER NOTES:

MOVEMENT

Would you consider yourself flexible? Y N
Can you squat past 90 degrees without your heels lifting off the ground? Y N
Do you suffer from joint or muscle pain after partaking in day to day activities/exercise? Y N
Have you ever had your movement patterns assessed? Y N
How many hours do you spend working on your mobility and stability a week? 0 1-3 4-6 7+ (hours)

PRACTITIONER NOTES:

OFFICE USE ONLY: FILE #: _____

ABOUT YOUR HEALTH

Please check the appropriate boxes for symptoms that you have experienced:

MUSCLE AND JOINT
- O Backache
- O Neck pain
- O Painful tailbone
- O Foot trouble
- O Shoulder pain
- O Herniated disc
- O Spinal curvature
- O Faulty posture
- O Arthritis

STRESS SYMPTOMS
- O Headaches/Migraines
- O Dizziness
- O Numbness
- O Ringing in ears
- O Blurring of vision
- O Loss of sleep
- O Loss of concentration
- O Irritable/Nervousness
- O Depression
- O Decreased Energy/fatigue
- O Tension

RESPIRATORY
- O Spitting up phlegm/blood
- O Chest pain
- O Difficulty breathing

URINARY
- O Painful urination
- O Urinating at night
- O Blood in urine
- O Increased urination

GASTROINTESTINAL
- O Difficult digestion
- O Belching or gas
- O Nausea or vomiting
- O Pain over stomach
- O Constipation
- O Colon trouble
- O Liver trouble
- O Gall bladder trouble
- O Heartburn
- O Diarrhea
- O Bloody stools

CARDIOVASULAR
- O Rapid heart beat
- O Slow heart beat
- O High blood pressure
- O Low blood pressure
- O Pain over heart
- O Swelling of ankles
- O Previous heart attack
- O Poor circulation
- O Previous stroke
- O Heart Disease

GENERAL
- O Fever/chills/sweat
- O Fainting
- O Convulsions
- O Skin problems
- O Colds
- O Tremors
- O Loss of balance
- O Allergies:

_____

_____

EYES, EARS, NOSE, THROAT
- O Deafness
- O Earache
- O Sore throat
- O Asthma
- O Tonsillitis
- O Sinus trouble

FEMALES ONLY
- O Painful menstruation
- O Excessive flow
- O Irregular cycle
- O Cramps or backache
- O Abnormal discharge
- O Past menopause
- O Birth control pill

First day of last menstrual cycle:_____

Are you pregnant? YES / NO

Due Date: _____

Previous no. of miscarriages: _____

PAST HEALTH
- O Thyroid troubles
- O Diabetes
- O Tuberculous
- O Emotional problems
- O Epileptic seizures
- O Alcoholism
- O Polio
- O Cancer
- O Venereal disease
- O HIV

MEDICATIONS:

_____

_____

_____

_____

ACCIDENTS/SURGERIES:

_____

_____

_____

_____

_____

FAMILY HEALTH HISTORY
- O Heart disease
- O Diabetes
- O Cancer
- O Fatigue
- O Asthma
- O High blood pressure
- O Low blood pressure
- O Thyroid
- O Arthritis
- O Low back pain
- O Anxiety
- O Scoliosis

PRACTITIONER NOTES:

PATIENT HEALTH HISTORY

What is your major symptom? _____

When was the first time you noticed this problem? _____

How did it originally occur? _____

Has it become worse recently? ___Yes ___No ___Same ___Better ___ Gradually

If yes, when and how? _____

How frequent is the condition? ___Constant ___Daily ___Intermittent ___Nightly

How long does it last? ___All day ___Few hours ___Minutes

Do you have any other conditions or symptoms that may be related to your major symptom? ___Yes ___No

If yes, _____

Are there other unrelated health problems? ___Yes ___No

If yes, _____

Describe the pain: __Sharp ___Dull ___Numbness ___Tingling ___ Aching __Burning ___ Stabbing

Other: _____

Is there anything you can do to relieve the problem? __Yes ___No If yes, how? _____

If no, what have you tried that has not helped? _____

What makes the problem worse? __Standing ___Sitting ___Laying ___Bending ___ Lifting __Twisting

Other: _____

Have you had any broken bones? ___Yes ___No

If yes, list with dates: _____

Have you had any diseases, major illnesses or injuries not indicated on this form either in the past or the present?

___Yes ___No If yes, _____

SYMPTOM SCALE *(please draw a line on the following scale)*

NO SYMPTOMS ——————————————— EXTREME SYMPTOMS

CONSENT TO CARE

I, _____ consent to receiving rehabilitation services, and/or a consultation, an examination and x-rays, (if necessary) to determine if I am a candidate for care at PURE.

Services may include: heat therapy, muscular stimulation, acupuncture, joint/spinal mobilization/manipulation, myofascial release, interferential, gait analysis, and exercise prescription.

I understand that health practitioners within PURE may share my health information between them in order to give me the highest level of care. I understand that all information shared between practitioners will remain completely confidential within PURE.

Signature:_____ Date:_____

Print Name : _____ Witnessed: _____