Ottawa Chiropractic Health Clinic & Physiotherapy

James Michael Schuster
Physiotherapist
407 Laurier Avenue W. • Ground Floor
Ottawa • ON • K1R 7Y7
Tel: (613) 233-8700 • Fax: (613) 233-8782
www.ochconline.com • info@ochconline.com

Health Questionnaire

Date of consultation: _____ Gender: Female ❑ Male ❑
Name: _____
Date of Birth: ( ) Day • ( ) Month • ( ) Year • Age: _____
Address: _____
Town: _____ • Province: _____ • Postal Code: _____
Telephone • Home: _____ • Work: _____ ext. _____
Cellphone: _____ • E-mail: _____
❑ **Yes,** you may contact me via e-mail to send appointment reminders, statements and any important information regarding the clinic.
❑ **No,** I do not want to be contacted via e-mail.
Occupation: _____
Emergency contact: _____ • Relationship: _____
Emergency contact's phone number: _____

How did you hear about us?

❑ Internet ❑ Portage ❑ Doctor: _____
❑ Other Health Professional: _____
❑ Recommendation from another client: _____
❑ Other: _____

Médical Doctor:

Name: _____ • Telephone: _____
X-rays, MRI, Ultrasound taken? ❑ Yes ❑ No • Date (if yes): _____
List medications you are taking and for what conditions: _____
_____
Date of last medical exam: _____

What is your major complaint (pain/symptoms)? _____

Other complaint? _____

How low have you had this condition? _____

What are your goals for physiotherapy? _____

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Past Health History:

Please check (☑) if you have any of the following conditions. Please circle those conditions or symptoms which have been a problem to you in the past.

- ❑ Allergies
- ❑ Anxiety/Panic Attack
- ❑ Arthritis
- ❑ Asthma
- ❑ Blurred Vision
- ❑ Cancer
- ❑ Chest Pain
- ❑ Chronic Coughing
- ❑ Congestive Heart Failure
- ❑ Constipation
- ❑ Diabetes
- ❑ Diarrhea
- ❑ Difficulty Breathing
- ❑ Dizziness
- ❑ Fever
- ❑ Headaches
- ❑ Heart Condition
- ❑ Hernia
- ❑ High Blood Pressure
- ❑ Kidney Infection
- ❑ Loss of Weight
- ❑ Low Blood Pressure
- ❑ Nausea
- ❑ Numbness
- ❑ Rashes
- ❑ Skin Problems
- ❑ Sweats
- ❑ Trouble Urinating
- ❑ Vomiting
- ❑ Weakness

Is there anything else we should know?

_____

_____

_____

_____

_____

_____

_____

Thank you!

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Consent for Joint Manipulation

Joint Manipulations consist of a high velocity, low amplitude thrust on a bone to allow motion of a joint. It is a safe and effective method to reinstate motion in a joint and reduce the pain in your muscles in the surrounding area. There is often a " POP " or " CLICK "that may occur, this is simply air pressure releasing. Your physiotherapist will determine whether you are a suitable candidate for manipulation before this technique is performed. This decision will be guided by the results of your physical examination and knowledge of your relevant health history.

Mild temporary side effects can occur with joint manipulations. These include, but are not limited to, local discomfort, numbness, dizziness, and/or headaches. More serious side effects are much less frequent but can occur. These include, but are not limited to, worsening of symptoms, nerve or disk injury, fracture, and rarely, with neck manipulation, stroke and death. Estimates of the risk of serious side effects from a neck manipulation vary widely, 1/50 000 to 1/5.85 million, but the risk appears " smaller than that associated with many commonly used diagnostic tests or prescription drugs. "

Joint manipulation may not be appropriate if you:

___ are pregnant
___ have a collagen disorder
___ have ligament laxity
___ have a pacemaker or a heart condition
___ have a deficient bone density
___ have a history of stroke

I hereby acknowledged that I have discussed with the physiotherapist the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to joint manipulations as proposed to me.

_____
Name (Please print)

_____ Date : _____, 20_____
Signature of patient (or legal guardian)