ACTION HEALTH

7722 Elbow Drive SW Calgary, AB T2V 1K2 | Ph. 403-243-8114 FX. 403-212-0880

NEW PATIENT INFORMATION

Full Name: _____ Preferred Name: _____

Date of Birth (MM/DD/YYYY): _____ Sex: □ MALE □ FEMALE

Gender: □ MALE □ FEMALE □ Other: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Email Address (for appointment reminders and monthly newsletters)

_____

Alberta Health Care: _____

Is this injury the result of a work-related accident or a motor vehicle accident? □ YES □ NO

If yes, please give the date of the accident: _____

Do you have group benefits? □ YES □ NO

Insurance Company:_____ Plan Member's Name:_____

Member ID/Certificate Number / Policy/Contract / Name of Primary Policy Holder

_____ / _____ /_____

Emergency Contact Name and Phone Number: _____

Who may we thank for referring you? _____

Occupation: _____

Employer's Address (if known): _____

Family Doctor's Name: _____ Phone Number: _____

ADDRESSING WHAT BROUGHT YOU INTO OUR OFFICE

If you have no symptoms or complaints and are here for Optimal Health and Wellness Services, please write "wellness" in health concern section and proceed to the section to list any medications you are taking.

Please list your health concerns according to their severity	Rate of severity 1=very mild 10 = worst imaginable	When did this episode start?	If you have had this condition before, when?	Is this caused by a work injury or car accident?	% of the time pain/symptom is present
1.					
2.					
3.					
4.					

Please answer the following sections in the same order you completed the chart listing your health concerns.

What do you feel caused your problem(s)? If you have ever injured that body part, please briefly describe when and how the injury happened.

Injury relating to Health Concern #1. _____

Health Concern #2. _____

Health Concern #3. _____

Health Concern #4. _____

Does your pain/symptom radiate to other parts of your body? If yes, please describe where it radiates to.

Radiating Symptoms relating to Health Concern #1. _____

Health Concern #2. _____

Health Concern #3. _____

Health Concern #4. _____

Is your condition getting better, worse or staying about the same over time?

Health Concern #1 □ getting better □ getting worse □ staying about the same

Health Concern #2 □ getting better □ getting worse □ staying about the same

Health Concern #3 □ getting better □ getting worse □ staying about the same

Health Concern #4 □ getting better □ getting worse □ staying about the same

Please describe what you feel in more detail. Check all that apply for each condition.

Health Concern #1 □ SHARP □ DULL □ NUMB □ TINGLING □ ACHING □ BURNING □ STABBING

□ OTHER: _____

Health Concern #2 □ SHARP □ DULL □ NUMB □ TINGLING □ ACHING □ BURNING □ STABBING

□ OTHER: _____

Health Concern #3 □ SHARP □ DULL □ NUMB □ TINGLING □ ACHING □ BURNING □ STABBING

□ OTHER: _____

Health Concern #4 □ SHARP □ DULL □ NUMB □ TINGLING □ ACHING □ BURNING □ STABBING

□ OTHER: _____

Have you found anything that makes your pain/symptoms worse?

Health Concern #1. _____

Health Concern #2. _____

Health Concern #3. _____

Health Concern #4. _____

Have you found anything that makes your pain/symptoms better? If medications help please list which medications.

Health Concern #1. _____

Health Concern #2. _____

Health Concern #3. _____

Health Concern #4. _____

Have you had this problem treated before? If yes, what treatment was done?

Health Concern #1. _____

Health Concern #2. _____

Health Concern #3. _____

Health Concern #4. _____

Please list any medications that you are taking for any health problem(s) including over the counter medications

_____

Have you received x-rays, MRI, CT, Ultrasound, or other imaging tests in the last 2 years?

□ YES □ NO

Area of your body that images was investigated: _____

To your knowledge, have you had any diseases, major illnesses, or injuries in the past or present that are not indicated on this form? □ YES □ NO

If yes, please explain: _____

To your knowledge, has anyone if your family has been diagnosed with the following:
□ CANCER □ DIABETES □ HEART DISEASE □ HIGH BLOOD PRESSURE □ STROKE □ OSTEOPOROSIS

Stressors

Because accumulation of stress impacts our health and ability to heal please list your top three stressors you have ever had in each category:

Physical Stress (falls, accidents, poor postures, bad workstation ergonomics, etc.).

1._____

2._____

3._____

Bio-chemical stress (smoke, unhealthy foods, don't drink enough water, drugs/alcohol, chemical exposure, etc.)

1._____

2._____

3._____

Psychological or mental/emotional stress (work, relationships, finances, anxiety, depression, etc.)

1._____

2._____

3._____

HEALTH HISTORY

Please check any of the following condition you have been diagnosed with:

- ☐ Atherosclerosis (Cardiovascular Disease)
- ☐ Marfan's Disease
- ☐ Multiple Sclerosis
- ☐ Heart Disease
- ☐ Osteopenia or Osteoporosis
- ☐ Psoriatic Arthritis
- ☐ Reiter's Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Ehlers-Danlos
- ☐ Arnold Chiari Malformation
- ☐ Seizures
- ☐ Cancer
- ☐ High blood pressure
- ☐ Eczema / Psoriasis
- ☐ Stroke
- ☐ Systemic Lupus Erythematosus
- ☐ Anklyosing Spondylitis (Marie Strumpell's)
- ☐ Enteropathic Arthritis
- ☐ Auto-Immune System Disorders
- ☐ Down Syndrome

Please check any of the following that you experience or have been diagnosed with, even if you do not think they relate to your primary health concern.

- ☐ Headaches
- ☐ Dizzy (lightheaded/ faint/ room spinning)
- ☐ Brain fog / spaciness
- ☐ Earaches / ringing in ears
- ☐ Sinus problems / nose bleeds
- ☐ Chronic fatigue / feel sluggish / tired all the time / low energy
- ☐ Anxiety / nervousness / feel overwhelmed /emotional
- ☐ Tingling / numbness in arms or hands
- ☐ Weight loss / weight gain
- ☐ Feel cold often / can't keep warm
- ☐ Craving sweets
- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Heartburn
- ☐ Bloating / gas / burping
- ☐ Stomach problems / ulcers
- ☐ Indigestion
- ☐ Tired after eating
- ☐ Heart palpitations / heart is racing
- ☐ Frequent colds / flus / "weak" immune system
- ☐ Stomach pain / digestive complaints after eating
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Swollen ankles
- ☐ Sciatica / pain down a leg or legs
- ☐ Tingling /numbness in legs or feet
- ☐ Abdominal cramps
- ☐ Bowel problems
- ☐ Bladder problems (leaking / accidents)
- ☐ Painful periods / PMS / menopause symptoms
- ☐ Hemorrhoids
- ☐ Allergies / food intolerance(s)

Thank You! Your responses will assist us in determining the most appropriate course of action for your care.