

Chiropractic Associates of Port Colborne (Carpal Tunnel Clinic)

Date: _____
 Name: _____
 Address: _____
 City: _____
 Postal Code: _____
 E-mail: _____
 Full name on Health Card: _____
 Health Card Number: _____

Please check the type of care desired.

- Temporary relief Lasting correction
 Check here if you want the doctor to select the type of care he feels is best for you.

Date of Birth: _____
Day Month Year
 Place of Birth: _____
 Home Phone Number: _____
 Cell Number: _____
 Version Code: _____

Check if you are: Married Single Widowed Separated Divorced
 Name of Spouse: _____ Ages of Children: _____
 Where are you or your spouse employed: _____
 Your days off: _____ Referred to our office by: _____
 Who is responsible for your bill?: Self Spouse Employer Other: _____
 How will payments be made?: Cash Cheque Interac Visa MasterCard
 Bank Name: _____ Address: _____
 Is this complaint resulting from a car accident: Yes No
 Is this a worker's compensation case? Yes No
 If YES Social Insurance Number: _____
 Date of Accident: _____
 Claim Number: _____
 Name and Address of Employer: _____

Medical History

Describe all surgery and dates: _____

Serious illness and dates: _____

Have you been treated for any health condition by a physician in the last year? If so, please describe: _____

Current medication or drugs: _____

Have you ever been diagnosed as having carpal tunnel syndrome? (Circle one) Y N

If yes, by whom: _____ Phone #: _____

If yes to above, what action was taken and/or current treatment: _____

How long has this condition existed and give history: _____

Describe work activities including % of time performing repetitive task: _____

Describe after work activities: _____

Symptoms (Check all that apply)

- | | | |
|---------------------------|-------------------------------|--------------------------------|
| Numbness in fingers/hands | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| Tingling | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| Night pain in hands | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| Intermittent pain | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| Loss of grip/clumsy hand | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| Unable to make fist | <input type="checkbox"/> Left | <input type="checkbox"/> Right |
| Constant pain | <input type="checkbox"/> Left | <input type="checkbox"/> Right |

Other symptoms: _____

If you have had previous testing to determine carpal tunnel syndrome, indicate below:

- | | |
|--------------------------------------|--------------|
| <input type="checkbox"/> MRI | Other: _____ |
| <input type="checkbox"/> X-ray | _____ |
| <input type="checkbox"/> EMG Needle | _____ |
| <input type="checkbox"/> Dynamometer | _____ |
| <input type="checkbox"/> S.S.E.P. | |
| <input type="checkbox"/> Vibrometer | |

Do you smoke: Yes No If yes, how much per day: _____

Do you consume alcohol: Yes No If yes, how much per day: _____

Have you been to a chiropractic office since last April 1st? Yes No

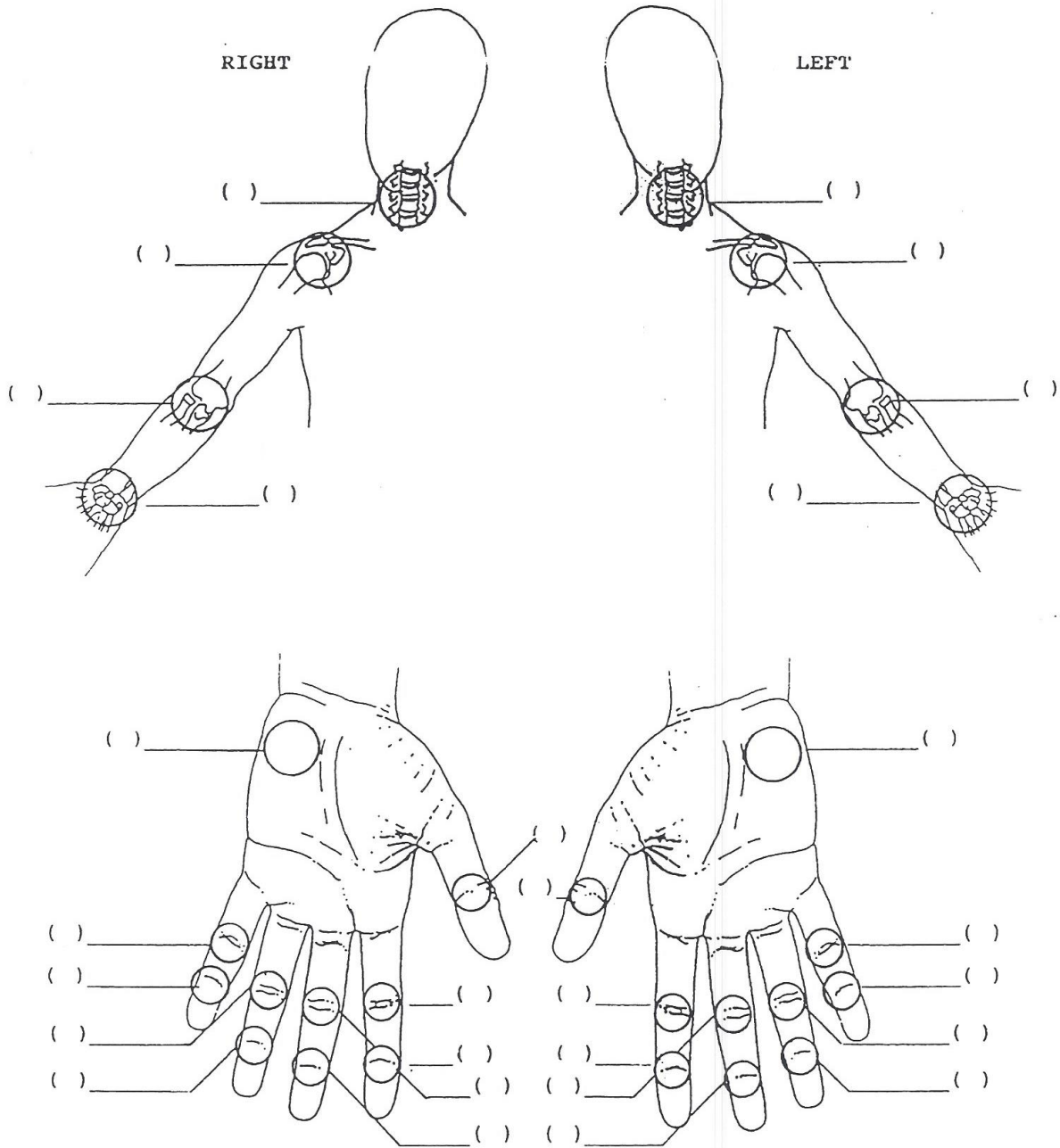
If yes, how many visits since last April 1st: _____

Payment is due at time of services unless previous arrangements have been made. Thank you.

Patient Signature

Date

Indicate area of pain with a check mark in the brackets



Describe other areas of pain not indicated above: _____

