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:_____

_____

CONTINUED ON REVERSE

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

_____

Describe after work activities:_____

_____

Symptoms (Check all that apply)

Numbness in fingers/hands	❑ Left	❑ Right
Tingling	❑ Left	❑ Right
Night pain in hands	❑ Left	❑ Right
Intermittent pain	❑ Left	❑ Right
Loss of grip/clumbsy hand	❑ Left	❑ Right
Unable to make fist	❑ Left	❑ Right
Constant pain	❑ Left	❑ Right

Other symptoms:_____

_____

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

❑ MRI
❑ X-ray
❑ EMG Needle
❑ Dynometer
❑ S.S.E.P.
❑ Vibrometer

Other:_____
_____
_____
_____

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.

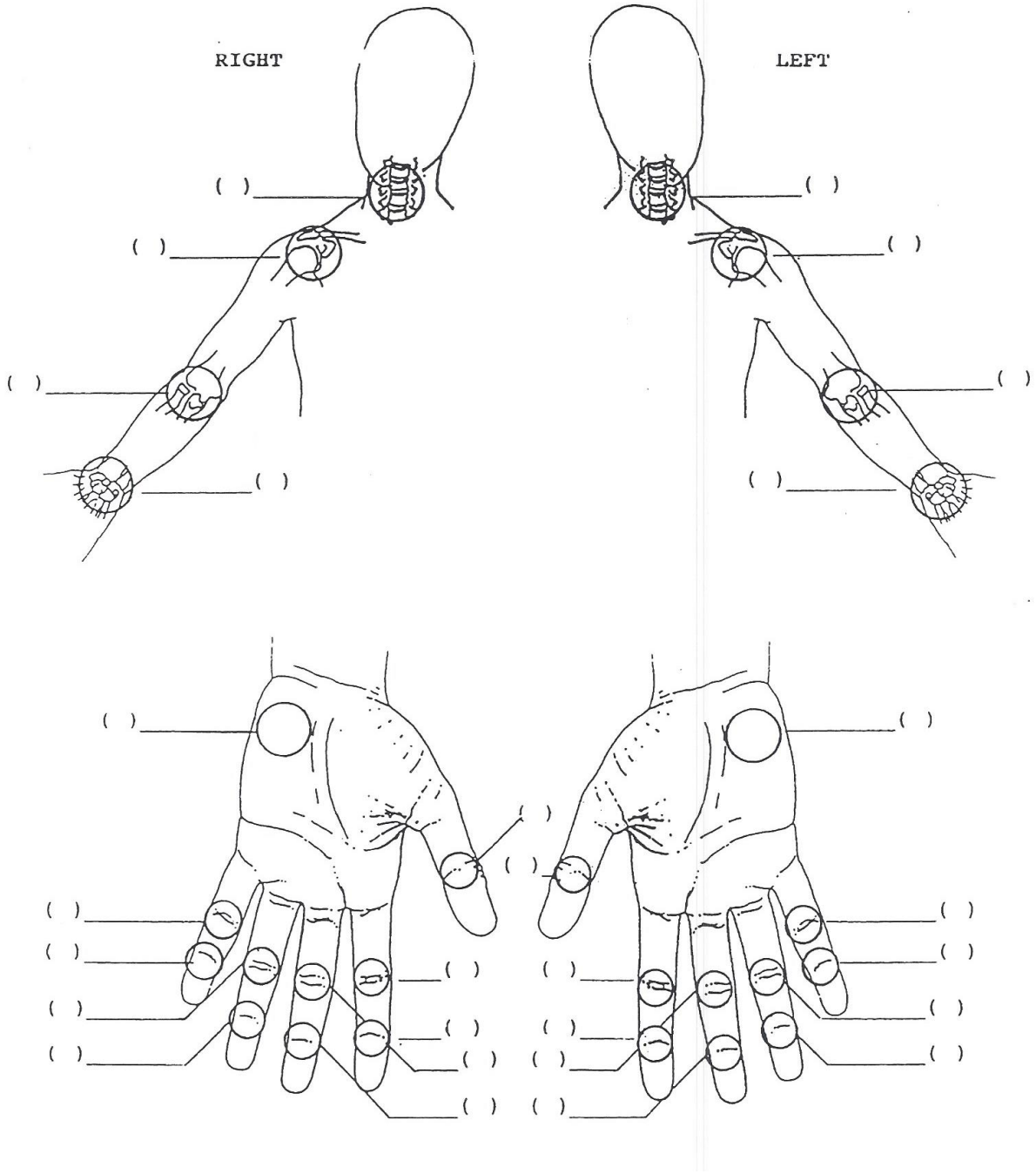
_____ _____

Patient Signature Date

(905) 835-1303
www.chiropracticassociates.com

Chiropractic Associates of Port Colborne

Indicate area of pain with a check mark in the brackets



Describe other areas of pain not indicated above:_____

_____

_____

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