**Date:** **Kinesis File #:**

**Name**

_____ _____ _____ Mr., Mrs., Ms., Dr.

Last First Middle Initial

| **Date of Birth** Day Month Year | **Age** | **Gender** M F | |
|---|---|---|---|

**Address**

#/Street_____Apt #_____

City_____

Province_____Postal Code_____

Home Phone _____

Email_____

*By providing my email address I consent to receiving appointment reminders by email, as well as the occasional newsletter, weather cancellations, promotional info, etc.

**Workplace and Address**

Institution/Place _____

Occupation/Student _____

Street_____

City_____

Province_____Postal Code_____

Work Phone_____

**Contact Person in Case of Emergency**

Name_____Relationship_____

Telephone # _____

**Previous Chiropractor**

Name_____Address_____

**Medical Doctor**

Name_____Address_____

**NS Health Card (MSI#)** _____

**Whom may we thank for referring you to our clinic?**

Name: _____Newspaper Advertisement_____

Yellow Pages Listing_____ Other, please state_____

***I grant permission to Kinesis Health Associates for sharing my confidential health information with my family doctor and other health professionals as necessary._____

**Patient Signature**

**Work Injury**

Is this a Worker's Compensation Case? Yes_____ No____ If Yes, Claim Number _____

Date of Accident: _____ Time of Accident_____

Contact Name/Title at Work:_____

**Motor Vehicle Accident / Personal Injury Insurance Information**

Date of Accident/Injury: _____

Insurance Company:_____ Claim Number: _____

Adjuster:_____ Telephone:_____

Address: _____ Fax: _____

**BLUE CROSS SUBSCRIBERS** **Policy Number**:_____

**Identification Number:**_____ **Effective Date**: _____

*****IMPORTANT: By signing below you acknowledge that you are responsible for all charges if your WCB or Insurance Claim is not accepted or it is discontinued**

**Signature:** _____ **Date:** _____

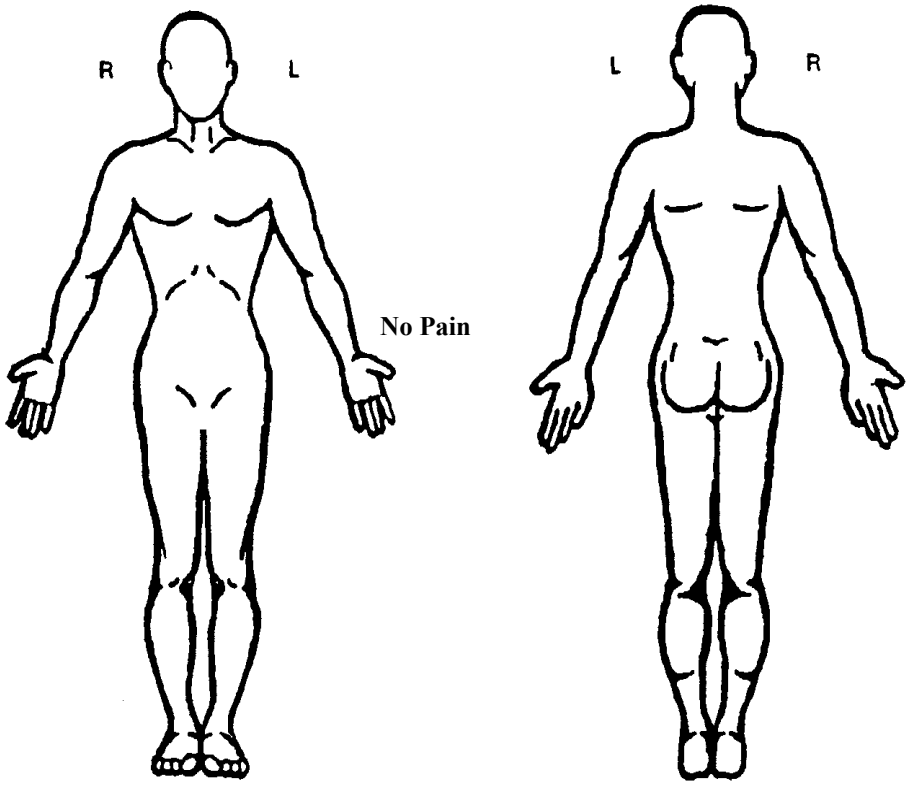
# Kinesis Health Associates
# Symptom Diagram

Patient Name: _____ File #: _____ Date: _____

In the diagram provided below, please mark the areas on your body that you feel best represent the pain(s) or sensation(s) you are experiencing. Please include all areas. Use the symbols provided below.

Symbols:

| | | | |
|---|---|---|---|
| **numbness** | **= = =**<br>**= = =** | **pins and needles** | *****<br>***** |
| **burning** | **X X X**<br>**X X X** | **stabbing &sharp** | /////////<br>///////// |
| **dull & aching** | **+ + + +**<br>**+ + + +** | **stiff and tight** | **2 2 2**<br>**2 2 2** |




**Front** **Back**

## Please fill in the following information:

**Pain Severity Scale**
**Rate the severity of your pain by checking one box on the following scale:**

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|

**BMI** _____ **HEIGHT** _____ **WEIGHT**_____

# KINESIS HEALTH ASSOCIATES
# PATIENT PAST HISTORY FORM

**Name:**_____ **Date:**_____

**Please check the appropriate box for any of the following symptoms which you now have or have previously had.**

**C = Constant F = Frequent O = Occasional**

**C F O**

**NEUROLOGICAL**

- ☐ ☐ ☐ Allergy
- ☐ ☐ ☐ Chills
- ☐ ☐ ☐ Convulsions
- ☐ ☐ ☐ Dizziness
- ☐ ☐ ☐ Fainting
- ☐ ☐ ☐ Fevers
- ☐ ☐ ☐ Headaches
- ☐ ☐ ☐ Loss of Sleep
- ☐ ☐ ☐ Nervousness
- ☐ ☐ ☐ Depression
- ☐ ☐ ☐ Neuralgia
- ☐ ☐ ☐ Numbness
- ☐ ☐ ☐ Sweats
- ☐ ☐ ☐ Loss of Weight
- ☐ ☐ ☐ Tremors

**MUSCLE & JOINT**

- ☐ ☐ ☐ Arthritis
- ☐ ☐ ☐ Bursitis
- ☐ ☐ ☐ Foot Trouble
- ☐ ☐ ☐ Hernia
- ☐ ☐ ☐ Low Back Pain
- ☐ ☐ ☐ Neck Pain
- ☐ ☐ ☐ Neck Stiffness
- ☐ ☐ ☐ Pain between Shoulders

**RESPIRATORY**

- ☐ ☐ ☐ Chest Pain
- ☐ ☐ ☐ Chronic Cough
- ☐ ☐ ☐ Difficulty Breathing
- ☐ ☐ ☐ Spitting Blood
- ☐ ☐ ☐ Throat Phlegm
- ☐ ☐ ☐ Wheezing

**EYES, EARS, NOSE & THROAT**

- ☐ ☐ ☐ Colds
- ☐ ☐ ☐ Crossed Eyes
- ☐ ☐ ☐ Deafness
- ☐ ☐ ☐ Dental Decay
- ☐ ☐ ☐ Asthma
- ☐ ☐ ☐ Ear Aches
- ☐ ☐ ☐ Ear Discharges

**C F O**

- ☐ ☐ ☐ Ear Noises
- ☐ ☐ ☐ Sinus Infections
- ☐ ☐ ☐ Enlarged Glands
- ☐ ☐ ☐ Enlarges Thyroid
- ☐ ☐ ☐ Sore Throat
- ☐ ☐ ☐ Tonsillitis
- ☐ ☐ ☐ Eye Pain
- ☐ ☐ ☐ Failing Vision
- ☐ ☐ ☐ Far Sighted
- ☐ ☐ ☐ Gum trouble
- ☐ ☐ ☐ Hay Fever
- ☐ ☐ ☐ Hoarseness
- ☐ ☐ ☐ Nasal Obstruction
- ☐ ☐ ☐ Near Sighted
- ☐ ☐ ☐ Nosebleeds

**CARDIO-VASCULAR**

- ☐ ☐ ☐ Rapid Heart beats
- ☐ ☐ ☐ Slow Heart beat
- ☐ ☐ ☐ Swelling of Ankles
- ☐ ☐ ☐ Hardening of Arteries
- ☐ ☐ ☐ High Blood Pressure
- ☐ ☐ ☐ Low Blood Pressure
- ☐ ☐ ☐ Pain over Heart
- ☐ ☐ ☐ Poor Circulation

**GASTRO INTESTINAL**

- ☐ ☐ ☐ Excessive hunger
- ☐ ☐ ☐ Burping or Gas
- ☐ ☐ ☐ Liver Trouble
- ☐ ☐ ☐ Colitis
- ☐ ☐ ☐ Colon Trouble
- ☐ ☐ ☐ Constipation
- ☐ ☐ ☐ Diarrhea
- ☐ ☐ ☐ Difficult Digestion
- ☐ ☐ ☐ Distension of Abdomen
- ☐ ☐ ☐ Stomach Pain
- ☐ ☐ ☐ Gall Bladder Trouble
- ☐ ☐ ☐ Hemorrhoids
- ☐ ☐ ☐ Intestinal Worms
- ☐ ☐ ☐ Jaundice
- ☐ ☐ ☐ Poor Appetite
- ☐ ☐ ☐ Nausea
- ☐ ☐ ☐ Vomiting
- ☐ ☐ ☐ Vomit Blood

**C F O**

**SKIN**

- ☐ ☐ ☐ Boils
- ☐ ☐ ☐ Bruise Easily
- ☐ ☐ ☐ Dryness
- ☐ ☐ ☐ Hives or Allergy
- ☐ ☐ ☐ Itching
- ☐ ☐ ☐ Skin Rash
- ☐ ☐ ☐ Varicose Veins

**GENITO-URINARY**

- ☐ ☐ ☐ Bedwetting
- ☐ ☐ ☐ Blood in Urine
- ☐ ☐ ☐Frequent Urination
- ☐ ☐ ☐ Loss of Bladder Control
- ☐ ☐ ☐ Kidney Infection
- ☐ ☐ ☐ Painful Urination
- ☐ ☐ ☐ Prostate Trouble
- ☐ ☐ ☐ Pus in Urine
- ☐ ☐ ☐ Abnormal smell of urine

**PAIN OR NUMBNESS IN:**

- ☐ ☐ ☐ Shoulders
- ☐ ☐ ☐ Arms
- ☐ ☐ ☐ Hands
- ☐ ☐ ☐ Hips
- ☐ ☐ ☐ Legs
- ☐ ☐ ☐ Knees
- ☐ ☐ ☐ Ankles
- ☐ ☐ ☐ Feet
- ☐ ☐ ☐ Painful Tail Bone
- ☐ ☐ ☐ Sciatica
- ☐ ☐ ☐ Swollen Joints

**FOR WOMEN ONLY**

- ☐ ☐ ☐ Cramps
- ☐ ☐ ☐ Heavy Flow
- ☐ ☐ ☐ Light Flow

☐ ☐ ☐ **Irregular Cycle**
☐ ☐ ☐ **Painful Cycle**
☐ ☐ ☐ **Discharge**
☐ ☐ ☐ **Sore Breasts**

**Menopausal: ☐ Yes ☐ No**
**Last Menstruation date: _____**
**Pregnant: ☐ Yes ☐ No**
**Due Date**: _____

# Osteopathic Consent Form

- I understand that it is my responsibility to express all of my health concerns (both current and past) with my Osteopath, including any contagious or infectious conditions that I may have.
- I understand that for an accurate examination and/or treatment to be performed by the Osteopath I may have to remove certain items of clothing.
- I understand that Osteopathy is a manual therapy that uses touch to both diagnose and treat.
- I understand that discomfort may occur during and/or after my treatment. I understand that my practitioner will discuss what is typical to experience and I will fulfil my responsibility to report back anything that is unusual.
- I understand that if at any time I am not comfortable with and/or do not understand the purpose of any procedure I will ask the practitioner for further explanation/information.
- I understand that I can stop the assessment or treatment at any time for any reason.

Patient signature _____ Date _____

# Osteopathic Cancellation Policy

Osteopathic treatment at Kinesis Health Associates operates a strict cancellation policy. Please give 24 hours' notice of cancellation or rescheduling of any appointments.

- An appointment that is cancelled or rebooked on the same day as the current appointment will incur a $50 cancellation fee. Initial here…….
- An appointment that is **missed** or **forgotten** will be charged at the full price of the scheduled appointment. Initial here…….

I have read the cancellation policy and agree to abide to these rules as best as possible.

Patient signature _____ Date _____