□ Dr. Chapin, DC
□ Dr. Fligg, DC
□ Dr. Danson, DC
□ Dr. Weinberg, DC
□ Dr. Neale, DC
□ Dr. Sawa, DC
□ Dr. Aitcheson, DC
□ Dr. Welsh, DC
□ Z. Herskovits, P.T.
□ M. Duranai, P.T.

High Point Wellness Centre

1977 – 2017 Celebrating Our 40th Anniversary

□ J. Chan, RD
□ S. Vander Doelen, ND
□ V. Roy, RMT
□ V. Mendoza, RMT
□ G. Padrique, RMT
□ A. Jurkiewicz, RMT
□ S. Forrester, RMT
□ M. Bogovic, RMT
□ M. Parsons, RMT

Date: _____ **New Condition Patient Information**

Dr.'s Comments

Reason For Appointment: _____

Name: _____ DOB ____/____/____
month day yr

Home Phone#_____ work#_____ cell#_____

When did your condition begin? _____

Is this condition related to: □ Occupation □ Car Accident □ Home Injury
□ Fall □ Sports Injury □ Other
Has this condition occurred before? Yes □ No □
Have you seen any other Health Professional for this condition? No □: Yes □
Type _____ Results: _____

Are you taking any medication for this condition? No □ Yes □ _____

Is your pain worse in the… Morning □ Mid-day □ Evening □ All Day Long □

Rate your pain on the following scale (circle)… 1 2 3 4 5 6 7 8 9 10
mild…>…moderate……>...severe

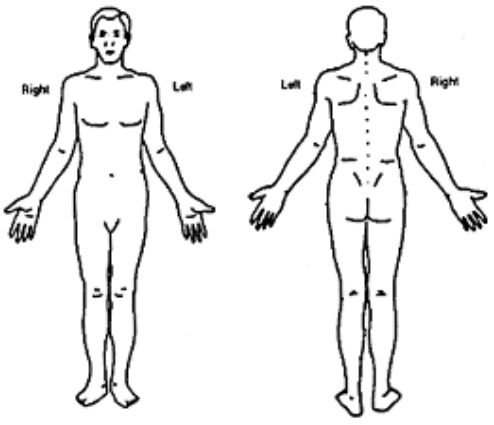
What aggravates your pain? _____

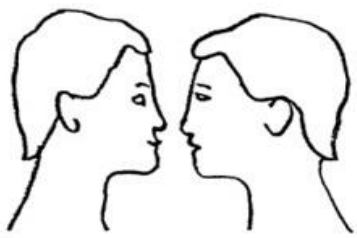
What gives you relief? _____

Does the pain affect your work, family, life, or recreational activities? **No** □ **Yes** □
Does this problem cause you stress, anxiety, depression…? **No** □ **Yes** □

Have you had X-Rays/CT, MRI, bone density taken? **No** □ **Yes** □ Date:

Location:





R **L**

5110 Creekbank Road, Suite 700, Mississauga, ON, L4W 0A1 Tel: (905) 624.0233 Fax: (905) 624.0881

LOCATION & SEVERITY OF PROBLEM

Symptom	L	R	Mild	Moderate	Severe
Headache					
Neck					
Shoulder					
Arm					
Elbow					
Wrist					
Hand					
Upper Back					
Chest (Ribs)					
Low Back					
Hip					
Thigh					
Knee					
Lower Leg					
Ankle					
Foot					
Other					
PLEASE DESCRIBE YOUR PAIN					
Stiffness					
Aching					
Burning					
Throbbing					
Sharp					
Stabbing					
Numbness					
Tingling					
Pressure					

Dr.'s Comments/Examination

□ **In the event that I am not available to answer the phone when called by the staff of the HPWC I hereby authorize the staff to leave a message for me regarding the details of my appointment at the phone numbers provided.**

Signature: _____

Date: _____

Witness: _____

Date: _____

Diagnosis/Clinical Impression/Treatment Recommendations

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