The
HEALING PATH
Chiropractic & Wellness Centre
2435 Appleby Line, Burlington ON L7L 0B6

Adult Health Questionnaire

Mohammed Adelbaky, BSc.PT, DPT, c/NDT

Name _____ Date _____ Gender _____

Address_____ City_____ Postal Code_____

Phone (H) _____ (W) _____ (C) _____

Occupation _____ Number of Children and Ages_____

Date of Birth (D/M/Y)_____ Family Doctor _____

Referred By _____ Email Address_____

Have you seen a Physiotherapist before? When? _____

Would you like to receive our monthly email newsletter? _____

Would you like to receive email reminders for your appointments? _____

Our Mission

We have created a chiropractic and wellness centre dedicated to your overall health as a human being. Our purpose is to remove interferences to the expression of your life, and to reveal to those who are interested, the source of true health and the manifestation of their fullest potential. We strive to spread this message to family, friends and the entire world.

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1. Is this a wellness check-up or do you have a specific health concern? If this is a health concern then please describe:

_____

_____

_____

_____

_____

2. Using the scale indicator, 0 – being least and 10 – being most, how is this condition interfering with;

Work	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Sleep	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Hobbies	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

3. Have you consulted anyone else for this condition?

_____

_____

4. Have you tried anything to get rid of this problem?

_____

_____

5. Please indicate which of these other symptoms you may have experienced in the last 6 months: (Please Circle)

Headaches	Tension	Upset stomach
Neck pain	Depression	Diarrhea
Back pain	Irritability	Constipation
Chest pain	Nervousness	Loss of smell
Shortness of breath	Loss of memory	Loss of taste
Fainting	Fever	Ringing in the ears
Dizziness	Cold sweats	Pins & needles leg
Sleeping problems	Cold hands	Pins & needles arm
Fatigue	Cold feet	Numbness in toes

6. Please answer the following health history questions:

a) Did / Do you smoke? _____

b) Did / Do you drink alcohol? _____

c) Do you recall any major childhood illnesses? _____

_____

d) Is this visit the result of a workplace injury?_____

e) Have you been involved in any car accidents? When? _____

_____

f) Have you had surgery or organs removed or replaced? _____

_____

g) Medications? (Prescriptive or Non-Prescriptive) _____

_____

h) Teeth problems? _____

i) Eye problems? _____

j) Hearing problem? _____

k) Physical exercise? _____

l) Sleeping position? _____

m) Did / Do you have occupational stress? _____

n) Physical stress? _____

o) Mental stress? _____

p) Hobbies / sports injuries? _____

q) Females: Is there any chance of a possible pregnancy? _____

About Your Care

Your initial physiotherapy visit will consist of a full musculoskeletal assessment to determine an accurate diagnosis of your condition. After being diagnosed the physiotherapist will educate the client on the particular condition and discuss a progressive goal oriented program of care that best fits your health care goals. The program of care will be initiated on the first visit and there will be subsequent re-evaluations during your follow up visits to best determine how to progress you towards optimal functioning until your discharge.

Initial Visit Fees

Consultation	----Complimentary----
Initial Visit	$110.00
45 Minute Treatment	$90.00
30 Minute Treatment	$70.00

Patient Signature: _____

Date: _____

The HEALING PATH
Chiropractic & Wellness Centre

Mohammed Abdelbaky
BSc.PT, DPT, c/NDT
Physiotherapist

Informed Consent:

I understand the terms and conditions associated with my assessment and treatment at The Healing Path, under the care of the Physiotherapist. I do voluntary give my consent to the assessment and treatment from the Physiotherapist. I have received information about the proposed physiotherapy and rehabilitation services, alternative courses of action, the benefits, risks and side effects of the services and the consequences of not having the service proposed. I wish to rely on the Physiotherapist to exercise judgement during the course of the procedure that he/she feels at the time, based upon the facts he/she then knows, is my best interest. The Physiotherapist has responded to all my requests for other information about the services proposed. _____ *Initials*

Associated Risks:

I have been informed of the potential risks associated with physiotherapy treatment. They include, but are not limited to burns from modalities, redness, increase discomfort, re-injury, muscle sprains and strains and fractured bones. I understand that I may have increased soreness following treatment and will inform the therapist immediately of any concerns. _____ *Initials*

Consent to Release Information:

I give my consent for the employees of The Healing Path to obtain and/or release information from/to physicians, lawyers, family members, insurance companies, case managers, hospitals or health care practitioners as deemed necessary for my continuing care . _____ *Initials*

Payment Responsibilities:

I understand that I am responsible for all fees incurred at The Healing Path associated with my treatment program and agree to pay any and all outstanding balances on my accounts. _____ *Initials*

Patient Name_____

Signature of Patient or Guardian_____ Date_____

Signature of Witness _____ Date_____