GUIDONIAN THERAPY CLINIC
38 Dupont St. E Waterloo, ON N2J 2G9 519-883-7225 www.guidonian.com

Confidential Case History

Date: ______________________

Name

Last Name: ____

First Name: ____

Date of Birth: Day ____________ Month ______________________ Year ____________

Address: ____

City: ____ Postal Code ____________________

Phone # : (home)_________________________ (work)_____________________________________

Email: ____

Occupation: ____

Emergency Contact: __________________________________ Phone: _______________________

Please check if you are currently seeing:
☐ Chiropractor ☐ Massage Therapist ☐ Physiotherapist ☐ Psychotherapist/Counselor ☐ Other

Family Physician Name: ____

Have you been diagnosed with any medical conditions: ______________________________________

Current Medications: ____

Previous Accident, Injuries or Surgeries ____
____

Allergies ____

Previous Xrays ____

Please check which most accurately describes your use of the following:

	Regular	Occasional	Never
Tobacco	☐	☐	☐
Alcohol	☐	☐	☐
Caffeine	☐	☐	☐
Exercise Regularly (i.e. 3x wk)		☐ Yes	☐ No

Current Discomfort:

Are you seeking treatment for a specific problem ______________________________

Or for maintenance / preventative care ☐ Yes ☐ No

How long have you had this condition/injury ? ______________________________

Please identify areas of current symptoms by indicating on the diagram below:

X for pain **O** for joint/muscle stiffness **///** for areas of numbness/tingling

Indicate on the scale where you feel your current level of pain/discomfort lies:

No Pain/Discomfort Extreme Pain

What increases your pain/discomfort? ______________________________

What relieves your pain/discomfort? ______________________________

Do you have any other concerns ? ______________________________

Indicate on the scale your motivation and attitude towards wellness

Passive Care Active Care

Health Care Provider's Responsibility Patient's Responsibility

Health History Review

*** Please indicate any condition or symptoms that you are currently experiencing or have been a problem in the past.

General
Insomnia
Fatigue
Weight Loss
Weight Gain

Head
Headache
Dizziness
Head Trauma
Fainting
Migraines
Loss of memory

Eyes
Itching/redness
Change in vision
Cataracts
Light sensitivity
Flashes in vision
Spots in vision
Blurred vision
Double vision
Glaucoma

Ears
Ringing/ Tinnitus
Impaired Hearing
Earache
Dizziness
Discharge

Mouth and Throat
Sore throat
Jaw/TMJ problems
Hoarseness
Swollen glands
Difficulty swallowing
Slurred speech

Nose
Hayfever
Loss of smell
Nosebleeds
Sinus problems

Lungs
Difficulty breathing
Persistent cough
Coughing phlegm
Coughing blood
Asthma
Pneumonia
Emphysema
Bronchitis

Skin
Rash
Itching/hives
Psoriasis
Eczema

CardioVascular
Pacemaker
Angina
Heart condition
Chest pain
Palpitations
Ankle swelling
Cold feet/hands
Leg cramps
Calf pain
Varicose veins
Low blood pressure
High blood pressure

Gastro-intestinal
Bloating/gas
Heartburn
Ulcers
Liver disease
Gall bladder disease
Vomiting/nausea
Abdominal pain
Diarrhea
Constipation
Blood in stool
Hernias

Urinary
Difficulty urinating
Pain urinating
Blood in urine
Incontinence
Bed-wetting
Urinary urgency
Frequent urination
Frequent infections
Kidney stones

Neurological
Seizures/epilepsy
Strokes
Tingling sensation
Numbness
Muscle weakness
Difficulty walking
Poor coordination

Muscle & Bone
Stiff Neck
Joint pain
Swollen joints
Muscle ache
Foot trouble
Bone pain
Fractures
Disclocations
Osteoporosis
Osteoarthritis
Artificial joints, Pins, Wires

Endocrine
Diabetes
Hypoglycemia
Hormone therapy
Thyroid problems
Heat/cold intolerance
Excessive thirst
Excessive hunger
Excessive sweating
Night sweats

Emotional
Depression
Mood swings
Anxiety/nervousness
Tension
Phobias
Alcohol/drug abuse

Conditions
AIDS/HIV
Eating disorders
Rheumatic Arthritis
Rheumatic fever
Cancer/tumor
Polio
Parkinson's
Multiple sclerosis
Gout
Anemia
Fibromyalgia
Chronic fatigue
Hepatitis

Female Care
Pregnancy
Heavy/Painful Menses

Patient
Initials

Policies and Procedures

In this office, all staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. This office will collect, use and disclose information about you for the following purposes:

- to enable us to contact you and maintain communication with you
- to communicate with other treating health-care providers, including referring doctors
- to allow us to maintain communication and contact with you to distribute health-care information and to book and confirm appointments
- to allow us to efficiently follow-up for treatment, care, and billing
- to comply with legal and regulatory requirements, including the delivery of patients' charts and records to governing bodies in a timely fashion, when required, according to the provisions of the Regulated Health Professions Act

I consent to the collection, use and/or disclosure of my personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information we will seek your approval in advance. ________

I consent to the following forms of communication: **Home phone/ voice mail**
Business phone/ voice mail
Cell/ voice mail
email

It is my responsibility to communicate with any health practician. I understand that during the course of treatment I am encouraged and have the right to ask questions about procedure or effects of my treatment. At any time before or during, I can ask the therapist to alter or stop the treatment. __________

Fee Schedule:

Chiropractic Initial & Subsequent Visits	$120/$50
Massage Therapy 1Hr.	$110
Osteopathic Treatment Initial & Subsequent Visits	$100

Payments are due on services rendered. I am aware that if insurance claims are being submitted on my behalf that I am responsible for any outstanding balance not covered by my insurance policy. Cancellation policy: Failure to provide 24 hours notice or repetitive cancellations will be charged full rate.

I have read and understand the Guidonian Therapy Clinic fee schedule and cancellation policy. __________

I consent to a physical examination, report of findings and diagnosis in the assessment of my musculoskeletal health and wellbeing. __________

Patient Signature: ____ **Date: ____________________**

Informed Consent

Manual therapy, including chiropractic, massage, physiotherapy and osteopathy has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms.

In accordance with the Code of Ethics and Standard of practice of the colleges of manual therapists of Ontario, health care providers are required to advise patients that there are or may be some risks associated with such treatment. In particular you should note:

a) The most common adverse effect some patients experience are short term aggravation of symptoms, minor bruising or muscle and ligament strains or sprains as a result of manual therapy techniques;

b) There are rare reported cases of disc injuries following cervical and lumbar spinal adjustments

c) All manual therapy has an associated risk of stroke. Although the apparent association is noted very infrequently, you are being advised of this possible association because stroke sometimes causes serious neurological impairment. Scientific evidence does not establish a definite cause and effect relationship between manual therapy to the cervical spine and the occurrence of stroke. The possibility of such injuries resulting from cervical spinal manipulation is extremely remote.

Our foremost concern is your health. If there is ever any information made available that could lower the already minimal risk of injury we would of course act accordingly. Your health care provider will always be available to answer your questions, address the concerns and discuss the nature and purpose of care in general and of your plan of care specifically.

As the client, I understand and agree that the anticipated effects of these treatments are not guaranteed and the therapist is not able to convey all the possible side effects that may occur. Furthermore, I understand that my therapist will practice under the scope of practise of their respective college.

I have read and understand the above information and by signing below l consent to the assessment, treatment and remedial exercise procedures I receive at the Guidonian Therapy Clinic. I authorize any information I have provided to be shared with any practitioner working within the Guidonian Therapy Clinic. I also understand that l can choose at any time to refuse care if l so choose.

I consent to the manual treatments offered or recommended to me by my doctor and/or therapist, and I intend this consent to apply to all my present and future care.

Name of Patient (print) ______________________________ Date ______________

Signature of Patient ____________________________________

Signature of Health Care Practician ________________________Date ______________

Physical Assessment

Patient Name :

Date:

Observations:
L
O
D
R
F
I
C
A
R
A

BP ___________

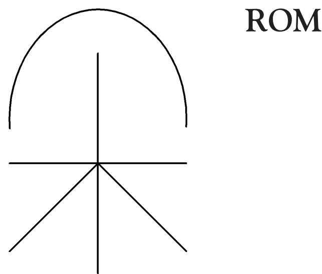
C/V exam

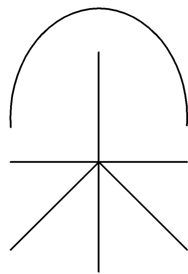
CN exam

Fam Hx

R.F.

ROM





Neurological

		C5	C6	C7	C8	L4	L5	S1
Motor	5							
Sensory	U/R							
Reflexes	2							
Babinski								
Heel/Toe								

Vertebral Subluxation

C0
C1
C2
C3
C4
C5
C6
C7
C8
T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12
L1
L2
L3
L4
L5
S1

LumboSacral

SLR L _______ R ____
Valsalva

Crossed SLR
Bowstring
Braggards

SI compression
Yeoman
Noble Compression
Thomas
Faber
Kemps

Leg Length L _______ R _______
Ely
Ober
Schober
Herron-Phesant's
Percussion

Cervical

Valsalva
Kemps
Cervical Compression
Spurling
Jacksons
Doorbell

EAST
Adson
Eden
Wright

Meningeal
Rotary Chair
Romberg
Percussion

Shoulder

Speeds
Yergason
Bear
Hornblowers
Full Can
Empty Can
Drop Arm
Neer Impingment
Hawkins-Kennedy
Scapular Winging
Apley's Scratch

Elbow / Hands

Phalen
Finklestein
Allan
Cozen
Mills
Tinel's
Varus/Valgus Stress
Resisted Finger Flexion
Ant. Interosseus - Pinch
Resisted Supination
Resisted Pronation

Knee

Noble Compression
McMurray
Varus/Valgus Stress
Ant/Post Glide
Slocum
Joint Line Tenderness

Foot/Ankle

Neuroma Squeeze
Plantar Fascititis
Homan's
Ant. Drawer

Muscle Findings:

Diagnosis