

NAME: _____ Mr Mrs Ms Miss Dr Rev
Last name First name Initial (please circle one of the above)

DATE OF BIRTH: Year _____ Month _____ Day _____ Ht _____ Wt. _____ Shoe Sz. _____

HOME ADDRESS: _____
Street City Province Postal Code

PHONE NUMBER: Home: _____ Cell: _____ Work: _____

EMAIL ADDRESS: _____

OCCUPATION: _____ **EMPLOYER:** _____

MEDICAL DOCTOR: _____ **HEALTH CARD#** _____

How did you hear about our office? _____

Who should we contact in case of emergency? _____ Phone # _____

What is your major complaint today? _____

How long have you had this condition? _____

Describe the onset of this condition? _____

Is the condition getting: (circle) Worse Same Better Consistent Recurring

How would you describe the pain? (circle) Aching Throbbing Tingling Numbness Burning
Shooting Intermittent Constant

Do you experience Numbness or Tingling to the arms or legs? YES NO

Is there a particular time of day when your complaint is worse? (circle)

Morning Afternoon Evening Night After activities

What activities are you unable to perform due to pain or functional impairment? (ie. golf)

Have you had this condition before? YES NO

Were XRAYs or other imaging performed? YES NO

What aggravates your condition? _____

What relieves your condition? _____

What types of treatment have you had for this condition? _____

Have you had previous chiropractic care? YES NO

If "yes" how long has it been since you were last treated? _____

DO YOU SUFFER –AT PRESENT- FROM ANY OF THE FOLLOWING

- () Fainting/ Spells/ Dizziness
- () Difficulty Sleeping
- () Pain that awakens you at night
- () General Tiredness/ Fatigue
- () Fever
- () Chills
- () Night sweats
- () Unexplained or unintentional Weight Loss

Current medications (including birth control)

List any surgeries/hospitalizations you've had & date

Supplements: _____

Have you suffered any fractures/dislocations?

HEALTH HABITS

Smoking: YES NO if "yes" how many years? _____ packs/day _____

Exercise: YES NO **Drinking Alcohol:** YES NO **Caffeine:** YES NO

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING

Neuromusculoskeletal

- () Convulsions
- () Headaches
- () Backache
- () Stiff neck
- () Pain between shoulders
- () Spinal curvature
- () Swollen joints
- () Weakness
- () Twitching
- () Numbness
- () Tremors

Skin or Allergies

- () Allergy
- () Bruise Easily
- () Dryness
- () Eczema
- () Sensitive Skin
- () Shingles

Other

- () Diabetes
- () Cancer
- () Depression/Anxiety

Cardiovascular

- () Heart disease
 - () High blood pressure
 - () Low blood pressure
 - () Stroke
 - () Varicose Veins
 - () Irregular heart beat
- Gastrointestinal***
- () Poor digestion
 - () Nausea/Vomiting
 - () Belging/Bloating/Gas
 - () Irritable bowel
 - () Hemorrhoids

Ear/Nose/Throat

- () Earaches
- () Frequent colds
- () Sinusitis
- () Hayfever

- () Alcoholism
- () HIV positive
- () Thyroid trouble

Respiratory

- () Chest Pain
- () Chronic cough
- () Difficulty breathing
- () Wheezing

Genitourinary

- () Bed wetting
- () Frequent urination
- () Painful urination
- () Prostate trouble
- () Inability to control urine

Women Only

- () Pregnant
- () Cramping /backache
- () Miscarriage
- () Irregular Cycle
- () Hot flashes/menopausal

Mark the areas on your body where you feel the following sensations:

Ache

^^
^^
^^

Numbness

ooo
ooo
ooo

Pins &
Needles

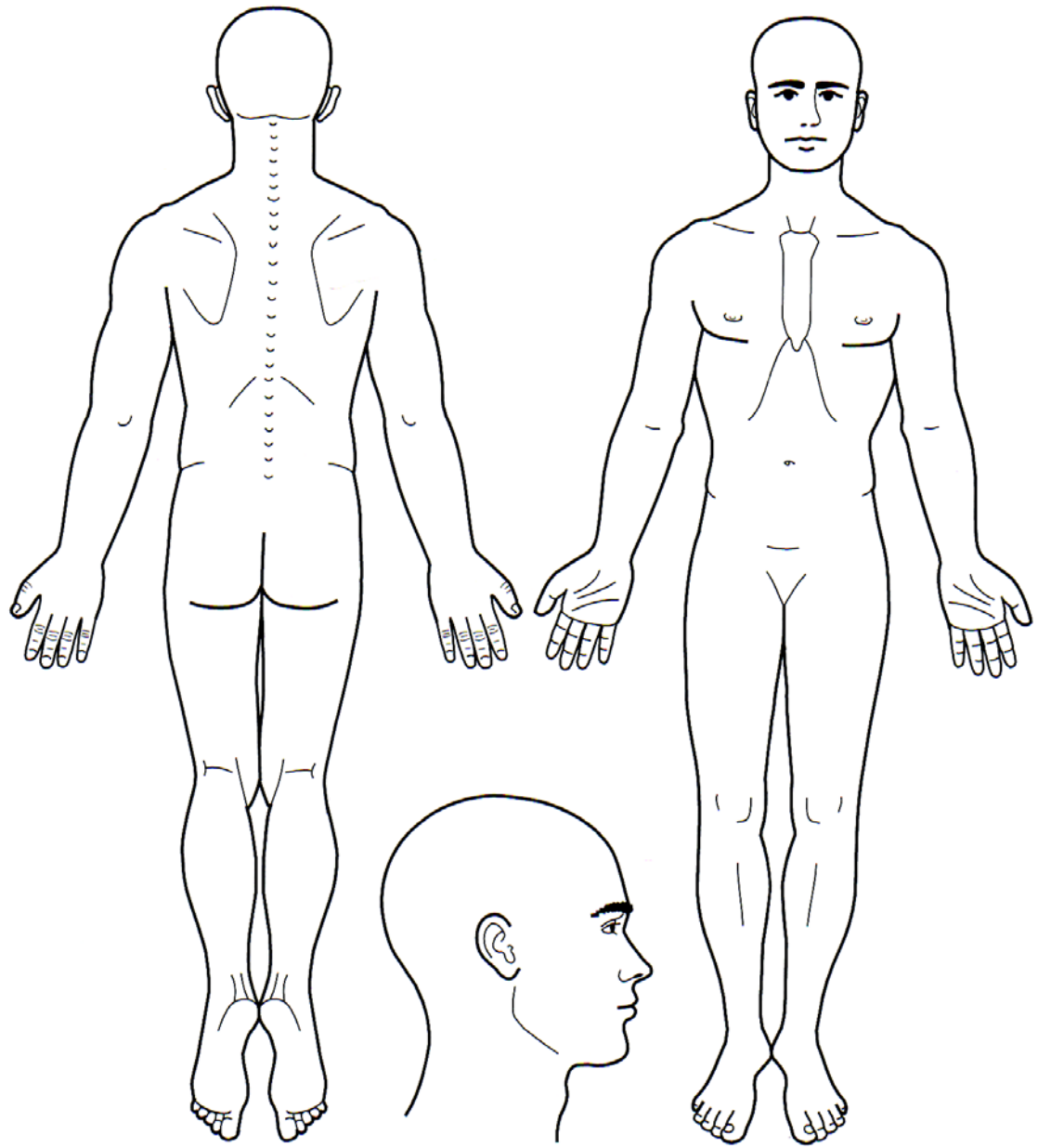
...
...
...

Burning

xxx
xxx
xxx

Stabbing

///
///
///



NAME _____

DATE _____

Measurement Tools and Instructions

Lower Extremity Functional Scale

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. **Please provide an answer for each activity.**

Today, do you or would you have any difficulty with:
(Circle one number on each line)

Activities	Extreme difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
A. Any of your usual work, housework, or school activities.	0	1	2	3	4
B. Your usual hobbies, recreational or sporting activities.	0	1	2	3	4
C. Getting into or out of the bath.	0	1	2	3	4
D. Walking between rooms.	0	1	2	3	4
E. Putting on your shoes or socks.	0	1	2	3	4
F. Squatting.	0	1	2	3	4
G. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
H. Performing light activities around your home.	0	1	2	3	4
I. Performing heavy activities around your home.	0	1	2	3	4
J. Getting into or out of a car.	0	1	2	3	4
K. Walking 2 blocks.	0	1	2	3	4
L. Walking a mile.	0	1	2	3	4
M. Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
N. Standing for 1 hour.	0	1	2	3	4
O. Sitting for 1 hour.	0	1	2	3	4
P. Running on even ground.	0	1	2	3	4
Q. Running on uneven ground.	0	1	2	3	4
R. Making sharp turns while running fast.	0	1	2	3	4
S. Hopping.	0	1	2	3	4
T. Rolling over in bed.	0	1	2	3	4
Column Totals:					

Minimum level of detectable change (90% Confidence): **9 points**

SCORE _____ / 80

Source: Binkley et al (1999): The Lower Extremity Functional Scale (LEFS): Scale development, measurement properties, and clinical application. Physical Therapy. 79: 371-383

KINETESIS SPORTS INJURY & PERFORMANCE CLINIC
FEE SCHEDULE

Chiropractic Services

Initial Consultation	\$100.00
Gait / Orthotic Assessment	\$75.00
Regular Office Visit	\$60.00

We direct bill Blue Cross for chiropractic services. All fees are due at the time services are rendered.