Confidential Patient Information Form

Please complete the following questionnaire as fully and carefully as possible. Your answers will help us to process your file, determine the nature of your injury, and decide how best to assist you. This information will remain strictly confidential.

CERTIFIED PROVIDER

PERSONAL INFORMATION

Name:_____ Date of Birth: ____/____/_____ (dd/mm/yyyy) Age:_____ M/F

Address:_____ City:_____ Postal Code: _____

Telephone: (home) _____ (work and/or cell) _____

Email: _____

Emergency Contact: (name/relation) _____ (Tel) _____

Current Occupation: _____

Name of Medical Doctor: _____ (Tel) _____

If Sport Related Injury:

Sport:_____ Team: _____

How were you referred to the Shift Concussion Management Program? _____

INJURY/DESCRIPTION OF COMPLAINT

Give a Brief Description of your Injury/Complaint (Include how it was sustained):

_____

_____

_____

Date of Injury/Symptom Onset: _____

For Head/Neck Pain:

Kingston West Family Chiropractic
743 Cataraqui Woods Drive, Unit 1 Kingston, ON K7P 2R1
613.389.5331 www.kwfc.ca info@kwfc.ca

On the drawings to the right, please mark painful areas with symbols given:

X	Sharp & Stabbing	△ Burning	Pins & Needles
S	Dull Ache	○ Numb	Stiff & Tight
☆	Pressure	# Throbbing	

Rate the following by circling a number:

Level of pain **now:** None 0 1 2 3 4 5 6 7 8 9 10 Worst ever felt

Level of pain **at its worst:** None 0 1 2 3 4 5 6 7 8 9 10 Worst ever felt

Is your pain: ☐ constant ☐ intermittent/random ☐ activity dependent ☐ not sure

POST CONCUSSION SYMPTOM SCALE

Please Indicate how you are feeling based on the **last 2 days:**

0 = NONE; 1-2 = Mild; 3-4 = Moderate; 5-6 = Severe

Headache	0 1 2 3 4 5 6	Sensitivity to Noise	0 1 2 3 4 5 6
Nausea	0 1 2 3 4 5 6	Irritability	0 1 2 3 4 5 6
Vomiting	0 1 2 3 4 5 6	Sadness	0 1 2 3 4 5 6
Balance Problems	0 1 2 3 4 5 6	Nervousness	0 1 2 3 4 5 6
Dizziness	0 1 2 3 4 5 6	Feeling more Emotional	0 1 2 3 4 5 6
Fatigue	0 1 2 3 4 5 6	Numbness or Tingling	0 1 2 3 4 5 6
Trouble Falling Asleep	0 1 2 3 4 5 6	Feeling Slowed Down	0 1 2 3 4 5 6
Sleeping more than Usual	0 1 2 3 4 5 6	Feeling Mentally "Foggy"	0 1 2 3 4 5 6
Sleeping less than Usual	0 1 2 3 4 5 6	Difficulty Concentrating	0 1 2 3 4 5 6
Drowsiness	0 1 2 3 4 5 6	Difficulty Remembering	0 1 2 3 4 5 6
Sensitivity to Light	0 1 2 3 4 5 6	Visual Problems	0 1 2 3 4 5 6

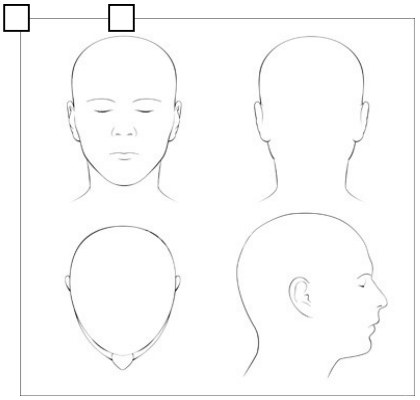
Overall, is your pain getting ☐ better? ☐ worse? ☐ staying relatively constant?

Have you sought medical evaluation for your current complaint before now? ☐ Yes ☐ No

If yes, indicate type: ☐ Family MD ☐ Sport MD ☐ Emerge MD ☐ Walk-in MD ☐ Other_____

Have you had any imaging for your current complaint (Xray, CT, MRI)?

☐ Yes ☐ No



Please list any medications, or supplements (e.g. vitamins) you are currently taking (including over-the-counter):

Do any of the conditions below apply to you? ☐ None

☐ ADHD ☐ Depression ☐ Migraine ☐ Learning Disability ☐ Sleep Disorder ☐ Anxiety

Are you currently experiencing any ongoing medical conditions not listed?_____

Have you had a routine eye exam in the last year? ☐No ☐Yes

PAST HEALTH HISTORY

Have you sustained any previous Concussions? ☐ No ☐ Yes If yes, indicate when they occurred and length of recovery:

_____

_____

_____

_____

Please indicate any previous **surgeries, hospitalizations, fractures, or traumas (other than concussion)** (include year):

_____

_____

_____

FAMILY HEALTH HISTORY

Have you or anyone in your immediate family had any of the following (please check those that apply):

☐Heart disease ☐High blood pressure ☐Cancer ☐Diabetes ☐Stroke ☐Other Disease

_____