

Back to Health Wellness Centre
Dr. Barbara A. Rodwin
240 Catherine St. Suite 100
Ottawa, Ont.
K2G 2G8
(613) 237-3306 Office
(613) 237-3100 fax
reception@back2health4you.com

New Patient Information

Please ensure the paperwork is returned to the office **24 hours prior to your appointment.**

Name:

Address:

City:

Province:

Postal Code:

Phone #:

Cell Phone #

Other:

Email address:

(We will not be using your e-mail address for any type of solicitation; it is merely another way to contact you if necessary)

Occupation:

Phone #:

Birthdate:

M

F

Age: Years

Day/Month/ Year

How did you find out about our clinic?

If there is a specific patient we may thank for your visit?

If you would like us to release information, appointment times, account information to your partner and/or family members please give us written permission below. We require your written permission with respect to this. **Your privacy is very important to us.** If you would like to review the contents of our privacy policy, please ask at reception.

Authorized family member's names: 1.

2.

3.

Patient's Signature:

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Day 1:

Exam

Duration: 30 minutes

We will perform a comprehensive exam to check joint movement, muscle function, range of motion to identify specific problem areas. This is a muscle, skeletal, biomechanical, neurological exam. The first part of the exam will be performed by Keri-Lyn our Kinesiologist. Part of this may be a foot scan/gait analysis using computer technology to identify any problems relating to your feet which may relate to the biomechanics of your body. Then Dr. Barbara Rodwin will complete the exam.

Please arrive 5 minutes early for your exam. We have specific time slots allotted for exams. If you are late, we either have to re-schedule your appointment or Dr. Rodwin will only be able to perform a portion of your exam.

Day 2:

Report of findings

Duration: 30 -45 minutes

Dr. Barbara Rodwin and Keri-Lyn will be reviewing your exam findings. They will prepare a written report detailing the results. Keri-Lyn will be reviewing this with you. Any recommendations will be made to aid in treating your condition. After Keri-Lyn has reviewed this you will be seeing Dr. Barbara Rodwin for treatment.

DR. RODWIN'S HOURS

Monday	7:00am – 12:30pm & 5:00pm – 6:30pm
Tuesday	----- 12:00pm - 6:30pm
Wednesday	7:00am – 12:30pm -----
Thursday	----- 1:00pm - 6:30pm
Friday	7:00am -12:00pm -----

Chiropractic Health Assistants are: Connie Correia and Debbie Lennox

Office manager is: Leona Lortie

Kinesiologist/Therapist is: Keri-Lyn Dudgeon B.Sc. (H.K.)

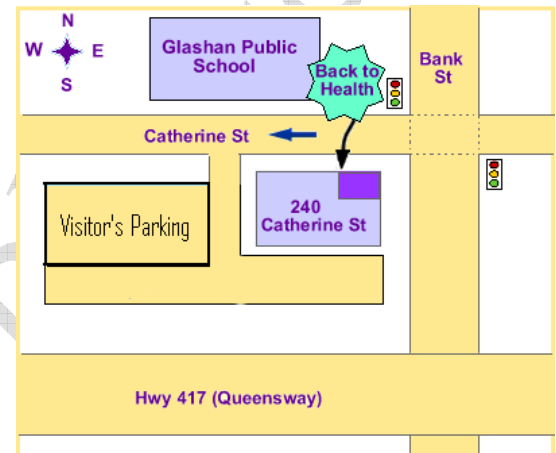
Emails: Reception@back2health4you.com, Leona@back2health4you.com, keri-lyn@back2health4you.com

No Scents Policy

At Back to Health Wellness Center we have a scents policy. This policy is for the health and comfort of the health care practitioners, employees and patients of Back to Health. *Please avoid wearing perfumes, colognes and other personal hygiene products that **have any scent.*** These scents can linger in the air as well as remain on the hands of the health care practitioners as many scents are not easily washed off.

Location

We are located at 240 Catherine St. Suite 100. **Effective July 13, 2009**, there are 3 rows of visitor parking available. These are the first 3 rows to the right of the building. The cost is \$1/hour or \$12/daily maximum. The remainder of the parking lot is for permit holders only. You can also get to the clinic by bus on Route # 4 and # 7.



Directions:

From the Queensway East bound:

- Exit at Kent St.
- Turn right onto Arlington
- Turn right on Bank, and,
- Turn right onto Catherine
- The clinic is on the left at the corner of Bank and Catherine

From the Queensway West bound:

- Exit at Catherine St.
- Cross Bank St.
- The clinic is on the left (just through the Bank intersection) at the corner of Catherine and Bank St.

By Bus:

- The #1, #4 and #7 go by the clinic at Bank St.
- The #99 goes by the clinic at Catherine St.

APRIL 2009

Bank Street is under construction until the Fall of 2009. If you take a bus they are being re-routed and if you are coming from the West end you need to take the Bronson exit to Chamberlain (1st Left) to Bank. You can still go north to Catherine Street.

Please Keep This Page for your reference

Fee Schedule

<u>Service</u>	<u>Payment</u>
Examination	\$70.00
Report of findings	Included in exam fees
X-rays	OHIP covered
Missed appointment (we require 24 hours notice for a cancellation)	\$25.00
Progress check (re-exam)	\$30.00
Re-exam (<i>if you have not had treatment in one year</i>)	\$35.00
<u>Treatments</u>	
Chiropractic only	\$35.00
Chiropractic with Active release technique	\$45.00
Chiropractic with Acupuncture	\$45.00
Chiropractic with Interferential current therapy	\$45.00
Active release technique only	\$35.00
Acupuncture only	\$35.00
Interferential current therapy only	\$10.00
<u>Orthotics</u>	
Orthotics	\$415.00
Types: Dress, fashion cut, all sport (multi-purpose), marathon, cycling, figure skating, ski/skate, court golf, diabetic, arthritic	
Pro-sport/Arthritic	\$515.00
Types: Golf, hockey, skiing, football, baseball, tennis, basketball, soccer	
Sandal/ shoes with orthotics	\$515.00
Modifications	\$50- 80
Types: Top coat changes, re-surfacing of old orthotics	
Leather top coat ordered	\$20.00

Accepted payment methods – cash, debit card, American Express, Visa, MasterCard

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Dr. Barbara Rodwin

Welcome to our office!

Modern Chiropractic is a **natural method of health care**. In order to provide the best care possible, a thorough consultation and physical examination (x-rays if required) will be undertaken.

Treatment will be initiated only after you have been advised of the nature of your problem and all of your questions regarding your treatment are answered. If we find your complaint is not amenable to Chiropractic care, you will be referred to the appropriate health care professional.

Payment is due when service is rendered. If you have any difficulties, please discuss them with us.

I have read and reviewed the intake process (initial consultation, examination, and report of findings), and the fee schedule for chiropractic services, acupuncture and the Active Release Technique. If I have any questions regarding this process, I will discuss these with Dr. Rodwin and any questions regarding the fees, I will discuss these with the front desk staff.

Print Name:

Patient's Signature:

If you are returning the forms via email please type your name in the signature line.

Date:

IF YOU ARE UNDER 18 YEARS OF AGE, PARENT OR GUARDIAN MUST COMPLETE THIS PART.

I, _____, consent to have _____, my son/daughter/ward, treated by Dr. Barbara Rodwin on this date and on subsequent visits.

Date: _____ Signature: _____

Foot Scan/gait analysis information

Shoe size and width: (regular/wide/narrow) and (women's/men's)

Height:

Weight:

• Please bring your everyday and/or running shoes with you. Also your orthotics if you have them.

Please answer the following questions about your health:

Can you walk a kilometer comfortably?

Yes No

Do your feet hurt when you get out of bed?

Yes No

Are your legs/knees/ or feet sore by the end of day?

Yes No

Do you wear/have you worn orthotics in your shoes?

Yes No

If yes, how old are the orthotics?

After walking long distances/or running do your shins hurt?

Yes No

Do you experience numbness in your toes?

Yes No

Do you have extended health benefits?

Yes No

If **yes**, with which company?

Are you diabetic?

Yes No

Do you suffer from Rheumatoid arthritis or Osteoarthritis in your feet?

Yes No

Have you ever had surgery on your legs, knees, feet, ankles?

Yes No

If **yes**, please explain:

Chiropractic Health Information

(Please answer each question and if **yes** is answered please explain)

CURRENT PROBLEM

1. What is your main problem?

2. What makes it feel better?

3. What makes it feel worse?

4. a) How long have you had this condition?

b) Did the condition occur due to a particular incident?

5. Have you had this or a similar condition in the past? Yes No

If so, when and was this due to a particular incident?

6. Is this condition getting progressively worse? Yes No

If so, when did it get worse?

7. Is this condition interfering with your:
 Work Sleep Daily Routine

Sitting Standing Other:

Exercise-describe which ones:

8. How would you describe the discomfort you have? For instance is it dull, achy, deep, sharp, constant, or intermittent.

9. Do you feel any numbness, tingling, or pain into your arms, hands, fingers, legs or feet? Yes No

If so, where:

10. Have you ever had previous chiropractic care? Yes No

Doctor of Chiropractic's name:

Address:

Last Treatment Date:

What were you treated for?

11. a.) Was an x-ray / MRI / CT scan / Bone scan performed? Yes No
If yes, date, location and procedure: _____

b.) Have you been diagnosed with osteoporosis? Yes No
If yes, to what severity? _____

12. Have you had treatment for this problem from other health practitioners?
If so, who were they and describe the type of treatment?

If you are already a massage therapy patient at our clinic and you would like Dr. Rodwin to have access to your massage therapy file, please sign here:

OTHER PROBLEMS

13. Do you have any other problems? If so, where in your body and for how long? Please List:

14. How long has it been since you really felt good? _____

PAST MEDICAL HISTORY (BIRTH TO PRESENT)

15. Please list any surgical operations and the years they were performed.

16. Have you ever broken or fractured any bones? Yes No If so, which ones and when:

17. Have you ever sprained or strained a muscle or ligament? Yes No
If so, which ones and when:

18. Have you ever been involved in an auto accident(s)? Yes No
If so, when and please describe the accident.

19. Have you had any other personal injury or accident? Yes No
If yes, please describe:

GENERAL HEALTH QUESTIONS

20. A) Are you currently taking any medication? Yes No

If yes, what kind and dosage:

B) Do you smoke or have you ever smoked? Yes No

If yes, for how long?

--

21. Do you currently take any vitamins, minerals, homeopathic or herbal remedies? Yes No

If yes, what kind and dosage:

WORK QUESTIONS

22. Please describe what you do during your work day. (standing, sitting at computer, driving, lifting, hammering, etc)

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23. If at a desk, is your computer in front of you or off to the side?

24. Is your keyboard on the desk or on a keyboard tray?

25. Do you mouse left or right handed?

25. Do you sit back into your chair, lean forward or a combination of both?

26. Do you make use of a footstool for your feet? Yes No

DAILY ACTIVITY QUESTIONS

27. A) What is the age of your mattress?

--

B) Would you describe it as: soft medium firm

C) What is the age of your pillow?

--

D) Is your pillow: Flat or Contoured

E) How do you sleep? On your:

Stomach Back Right Side Left Side

Combination of several:

--

28. Do you often wear: Yes No If yes, are they:

Heel lifts

Off the shelf store bought insoles/orthotics

Custom Orthotics

How old are they?

When is the last time they were checked?

29. What are your interests and hobbies? List as well how often, the distances or time of each sport.

30. What is your Medical Doctor's name?

FAMILY MEDICAL HEALTH INFORMATION

Many health problems are the result of hereditary conditions. This information about your immediate family will give us a better picture of your total health. Please try to think of the health history of your **parents, siblings, grandparents, aunts and uncles**, related to you by blood and not by marriage.

If you do not know the health history of your family, please specify this here.

If you answer yes to any of the below questions please list the family members and which side of the family it is.

Neck or back problems: Yes No If yes, whom and how are they related:

Headaches or Migraines: Yes No If yes, whom and how are they related:

Osteoporosis Yes No If yes, whom and how are they related:

Arthritis: Yes No If yes, whom and how are they related:

Joint Replacements: Yes No If yes, whom and how are they related:

Cancer : Yes No *If yes, whom and how are they related:*

Tumors: Yes No *If yes, whom and how are they related:*

Heart Problems/conditions: Yes No *If yes, whom and how are they related:*

Strokes: Yes No *If yes, whom and how are they related:*

Asthma: Yes No *If yes, whom and how are they related:*

Allergies: Yes No *If yes, whom and how are they related:*

Diabetes: Yes No *If yes, whom and how are they related:*

Can you think of any other things that run in your family?

No Scents please