Back to Health Wellness Centre
New Patient Paperwork

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.

As a patient of Back to Health do you understand our scent policy and can we ask that you adhere to it?

Yes

☐

When attending your first appointment at the Back to Health Wellness Centre, please bring the following items: Shorts, a T-shirt, running shoes(older pair with use), your orthotics (if you have some), and any medical reports you may have.

NOTE: IF A FIELD DOES NOT APPLY PLEASE ANSWER "N/A" or NOT APPLICABLE

Patient Overview

Name

Address

City

Province

Postal Code

Occupation

E-mail

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

Phone

Cell phone

Occupation phone #

Birth Date

Age (in years)

Gender

Status

# of Children

Ages of Children

How did you find out about our clinic?

Do you have extended health benefits?

If yes, with which company?

Emergency Contact Information

Name

Relation

Phone

Email

Other Health Care Providers

Other Health Care Providers (Please list)

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 our front reception.

Authorized family member’s names (Please list)

Chiropractic Biomechanical Exam

Day 1: Exam - 45 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 include a foot scan/gait analysis using computer technology. This can 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 may 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 - 45mins-1hr

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.

Chiropractic/Orthotic Fee(s)

Service	Payment
Examination	$75.00
Report of findings	Included in exam fees
X-rays	OHIP covered
Missed appointments	$25.00

Progress check (re-exam)	$35.00
Re-exam (if you have not had treatment in over 2 years)	$40.00

Treatments

Chiropractic only	$38.00
Chiropractic with Active release technique	$48.00
Chiropractic with Acupuncture	$48.00
Chiropractic with Interferential current therapy	$48.00
Active release technique only	$38.00
Acupuncture only	$38.00
Interferential current therapy only	$28.00

Orthotics

Orthotics	$465.00
Types: Dress, fashion cut, all sport (multi-purpose), marathon, cycling, figure skating, ski/skate, court golf, diabetic, arthritic	
Pro-sport/Arthritic	$565.00
Types: Golf, hockey, skiing, football, baseball, tennis, basketball, soccer	
Sandal/ shoes with orthotics	$595.00
Modifications	$65-140
Types: Top coat changes, re-surfacing of old orthotics	

Massage Fees (Plus HST)

Time	Massage	Massage & ART	ART
15	$25.09	$38.00	$48.00
30	$47.38	$61.00	$70.00
45	$65.04	$81.00	$91.00
60	$79.91	$97.00	$113.00
75	$100.36	$124.00	$140.00
90	$115.31	$151.00	$167.00

Naturopathic Fees (Plus HST)

Naturopathic Appointment Type:	Time	Cost
Initial Visit (Adult/Child)	90	$185.00
Second Visit	60	$130.00
Follow-ups:	60	$130.00
	45	$97.50
	30	$65.00
	15	$32.50
Meet and greet	15	$0.00
Initial Visit (Students/Seniors)	90	$130.00
Second Visit	60	$100.00
Follow-ups:	60	$100.00
	45	$75.00
	30	$60.00
	15	$30.00
Initial Acupuncture Visit	75	$130.00
Follow-up Acupuncture Visit	45	$75.00
Cupping	30	$50.00
B12 Injection	15	$15.00

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

The health care practitioners at Back to Health Wellness Centre prefer to work together as a team in order to aid you in improving your overall health, function and problem. We ask that you allow us to share information regarding your current health status with the other practitioners you see. We find that patients improve quicker with this open line of communication. If at any time you would prefer that we not share this information please discuss this with your health care provider at the clinic.

Cancellation Policy

Our policy at Back to Health Wellness Centre is that we ask for at least 12 hours notice to cancel an appointment. Time is important to all of us. If you can't make it to an appointment, it is quite likely someone else could benefit from your slot.

You will be charged for a missed appointment if you do not show up for an appointment. If less than 12 hours' notice is given, we reserve the right to charge you the fee of the appointment that you originally scheduled.

Please be aware that private health care insurance plans do not cover the fee for missed appointments.

Thank you for your understanding.

Confirm Review of Intake Process

I have read and reviewed the intake process (initial consultation, examination, and report of findings) and sharing of health information between health care practitioners. I have also reviewed the fee schedule for massage services, chiropractic services, acupuncture and the Active Release Technique and the cancellation policy at Back to Health. If I have any questions regarding the initial intake process, I will discuss these with Dr. Rodwin and any questions regarding the fees, I will discuss these with the front desk staff.

Please type your name to acknowledge you understand our process

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 and/or a registered massage therapist on this date and on subsequent visits.

Enter your name to consent to above statement

Health Information

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

CURRENT PROBLEM

What is your main problem?

What makes it feel better?

What makes it feel worse?

How long have you had this condition?

Did the condition occur due to a particular incident?

Have you had this or a similar condition in the past?

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

Is this condition getting progressively worse?

If so, when did it get worse?

Is this condition interfering with your :

- [ ] Work
- [ ] Sleep
- [ ] Daily Routine
- [ ] Sitting
- [ ] Standing
- [ ] Exercising

Describe which ones

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

Do you feel any numbness, tingling, or pain into your arms, hands, fingers, legs or feet or toes?

If so where?

Have you ever had chiropractic before?

Doctor of Chiropractic’s information
(Doctor's name, address, last treatment date, and what you were treated for)

Have you ever had massage therapy before?

Registered massage therapist’s information
(Name, address, last treatment date, and what you were treated for)

Was an x-ray / MRI / CT scan / Bone scan performed?

If yes, date, location and procedure (x-ray / MRI / CT scan / Bone scan)

Have you been diagnosed with osteoporosis?

If yes, to what severity?

Have you had treatment for this problem from other health practitioners?

If so, who were they and describe the type of treatment?

Other Problems

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

How long has it been since you really felt good?

PAST MEDICAL HISTORY (BIRTH TO PRESENT)

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

Have you ever broken or fractured any bones?

If so, Which ones and when?

Have you ever sprained or strained a muscle or ligament?

If so, Which ones and when?

Have you ever been involved in an auto accident(s)?

If so, when and please describe the accident

Have you had any other personal injury or accident?

If yes, please describe

GENERAL HEALTH QUESTIONS

Are you currently taking any medication?
(please list Type/Dosage

Do you smoke or have you ever smoked?

If Yes, for how long and how much per day?

Do you currently take any vitamins, minerals, homeopathic or herbal remedies?*
(please name **Brand / Supplement Type / Dosage**

Brand	Supplement Type	Dosage

Do you have any internal pins, wires, artificial joints or other special equipment (such as a pacemaker or hearing aid)?
If yes, please explain

Shoe Size

Shoe Width

Shoe Sizing

Height

Weight

Can you walk a kilometer comfortably?

Do your feet hurt when you get out of bed?

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

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

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

WORK QUESTIONS

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

If at a desk, is your monitor placed

Do you use multiple monitors?

Is your keyboard

Do you mouse

How do you sit in your chair?

Do you make use of a footstool for your feet

DAILY ACTIVITY QUESTIONS

What is the age of your mattress?

Would you describe it as

What is the age of your pillow?

Is your pillow

How do you sleep? (right side, left side, stomach, or back)

Do you often wear heel lifts, off the shelf insoles/orthotics or custom orthotics?
(please specify)

How old are they?

When is the last time they were checked?

What are your interests and hobbies? Please list them below and as well how often, the distances or time of each sport or hobby.

What is your Medical Doctor’s information
(Name, address, phone number and your last physical)

DIET AND LIFESTYLE

Many of the following questions are for our naturopath’s required information

Do you eat or use any of the following? (check any that apply)

- ☐ Aluminum pans
- ☐ Air fresheners
- ☐ Fast foods
- ☐ Artificial Sweeteners
- ☐ Plastic tupperware
- ☐ Scented body products
- ☐ Refined/processed food
- ☐ Luncheon meats
- ☐ Microwave
- ☐ Fried foods
- ☐ Candy
- ☐ Margarine

Do you have any dietary restrictions? (Vegetarian, Religious, etc.)

How do you eat your meals? (check all that apply)

- ☐ With family around the table
- ☐ On the Run
- ☐ Fast food
- ☐ in front of the TV
- ☐ Restaurant

How often do you eat at a restaurant?

How often do you eat fast food?

Please describe what you typically eat in one day:

Breakfast

Lunch

Dinner

Snacks

Food likes/Cravings

Water (cups/day)

Milk (cups/day)

Coffee (cups/day)

Tea (cups/day)

Alcohol (cups/day)

Other

Do you have a bowel movement daily?

How stressful is your work, or other areas of your life?

How well do you feel you handle these stresses?

How many hours do you sleep daily?

Problems with sleep?

Do you wake feeling rested?

FEMALE REPRODUCTIVE SYSTEM

Are you possibly pregnant?

Expected due date

Describe your menstrual cycle

PMS Symptoms?

Do you take birth control?

Birth Control Method? (Pill, Injection, Nuvaring, other?)

Have you been diagnosed with, or have you ever experienced any of the following?

Circulatory/Respiratory

- ☐ Chronic congestive heart failure
- ☐ Another heart condition
- ☐ Low blood pressure
- ☐ Phlebitis
- ☐ Raynaud's disease/phenomenon
- ☐ Chronic cough
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Varicose veins
- ☐ Deep vein thrombosis
- ☐ Buerger's disease
- ☐ Bronchitis
- ☐ Emphysema

Nervous system

- ☐ Epilepsy
- ☐ Parkinson's
- ☐ Carpal tunnel syndrome
- ☐ Multiple sclerosis
- ☐ Nerve lesion
- ☐ Cerebral palsy
- ☐ Sciatica

Musculoskeletal

- ☐ Scoliosis
- ☐ Joint instability
- ☐ Jaw pain (TMJ)
- ☐ Bone or joint disease
- ☐ Tendinitis
- ☐ Whiplash
- ☐ Arthritis
- ☐ Fractured bones
- ☐ Concussion

Skin

- ☐ Sensitivities to oils, lotions, detergents
- ☐ Irritated skin conditions
- ☐ Frostbite
- ☐ Other allergies or hypersensitivities
- ☐ Contagious conditions
- ☐ Lack of sensation

General

- ☐ Cancer/Tumors
- ☐ Diabetes
- ☐ Liver problems
- ☐ Infectious conditions (hepatitis, HIV, etc.)
- ☐ Recent abortion or vaginal birth
- ☐ Undiagnosed lump
- ☐ Kidney problems
- ☐ Drug/Alcohol addiction or withdrawal
- ☐ Eating disorder
- ☐ Loss of vision or hearing

Allergies/Sensitivities (environmental, foods, pets, drugs, etc.)

Have you received all childhood vaccinations?

Do you get regular flu vaccinations?

Any complications from vaccinations?

Date of last Annual Physical Exam/Blood Test?

Date and reason for last antibiotic Use?

Have you ever suffered from a heart attack?
(if yes, when?)

Have you ever suffered from a stroke?
(if yes, when?)

Please list any other condition not listed & provide details as necessary

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

Headaches or Migraines

Osteoporosis

Arthritis

Joint Replacements

Cancer

Tumors

Heart Problems/conditions

Strokes

Allergies

Diabetes

Depression

Mental Illness

Drug/Alcohol abuse

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

Have you ever had massage therapy before? Registered massage therapist's information (Name, address, last treatment date, and what you were treated for)

If you see any of the health care professionals at Back to Health Wellness Centre, do you give permission for your health care providers to share to discuss your condition?*

Thank you for completing the New Patient Paperwork. Please choose one of the following methods to send this form to the Back to Health Wellness Centre:

Email
Choose "File" menu above and select "Attach to Email". Click on "Attach" on right hand side.
Send to reception@back2health4you.com

Print and Fax
Choose "File" menu above and select "Print"
Fax to 613-237-3100