full circle
A Collaborative Health Approach

#102, 506 - 71 Ave SW Calgary AB T2V 4V4
Ph 587.352.9199 • Fax 1.888.501.1724 • info@fullcirclecalgary.ca • www.fullcirclecalgary.ca

File # ________________

HEALTH INFORMATION FORM

Date: ________________

Part 1: BASIC INFORMATION

Name: ____ Sex: M ____ F ____

Address: ____________________________________ City: ____________________

Province: __________ Postal Code: ____________ Alberta Health Care Number: ____________________

Date of Birth (MM-DD-YY): ________________ Email: ______________________________

Cell Phone: ______________ Home Phone: ________________ Work Phone: ____________________

Occupation: ______________________________ Relationship: single ☐ married/common-law ☐ separated ☐

Emergency Contact Name: ________________________ Phone: ________________________

Whom may we thank for referring you to us? ____

Part 2: CONCERNS

What is the main issue or priority that you'd like to explore at your appointment?

____

____

____

When and/or how did this concern begin? ____________________________________

Has this occurred before? Yes ☐ No ☐

Is your concern getting: Worse ☐ Constant ☐ Comes/Goes ☐ Better ☐

Is this concern job or auto accident related? Yes ☐ No ☐

If so, when did the accident occur? ____________________________________

*** PLEASE NOTE THAT THIS OFFICE DOES NOT HANDLE WCB CLAIMS ***

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Please list who has been involved in your care, treatments and results:

Health care provider name	Type of Treatment	Results

What medications/supplements are you currently taking?

Supplement or Medication name	Condition	Dose	Is this effective?

Current or past use of: Blood Thinners Yes ☐ No ☐ Corticosteroids Yes ☐ No ☐ Prolotherapy Yes ☐ No ☐

Major Surgery/Operations/Significant Hospitalizations: Yes ☐ No ☐ If so, please describe: ______________________

____

Are there functional restrictions at work or home: Yes ☐ No ☐ If so, please describe: ______________________

____

Previous accidents/ injuries	Year	Specific information	Affected by injury Y/N	How Affected 0-5 0 not at all - very much 5					
Broken bones				0	1	2	3	4	5
Concussion				0	1	2	3	4	5
Joint problems				0	1	2	3	4	5
Whiplash				0	1	2	3	4	5
Muscle injuries				0	1	2	3	4	5
Other - please specify				0	1	2	3	4	5

What Activities / Sports do you participate in?	Hours per Week	Affected by injury Y/N	How Affected 0-5 0 not at all - very much 5					
			0	1	2	3	4	5
			0	1	2	3	4	5
			0	1	2	3	4	5

Do you have sleep issues? Yes ☐ No ☐ Do you feel you get enough &/or a restful sleep most nights? Yes ☐ No ☐

Please describe: ____

Are there any significant stressors/or other conditions that could be affecting your health & wellbeing? Yes ☐ No ☐

If so, please describe: ____

____

What are some specific goals/activities you would like to aim towards with your therapy? ______________________

____

Is there a bigger goal that you would like us to help you work towards? ______________________

____

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Health History

Below is a list of health conditions which may seem unrelated to the purpose of your appointment. However, please answer these questions carefully as these issues may can affect your overall plan of care.

Check any of the following issues that you've had, that have caused concern:

Chronic Conditions

- ☐Allergies:______________________
- ☐Auto Immune Disease ___________
- ☐ Heart Disease/Stroke
- ☐ Diabetes: _______________
- ☐ HIV / AIDS
- ☐ Chronic Infections:
- ☐ Cancer:
- ☐ Other:

Nervous System: Function & Feeling

- ☐ Seizures
- ☐ Confusion
- ☐ Forgetfulness
- ☐ Numbness/tingling
- ☐ Weakness/paralysis
- ☐ Poor Temperature Regulation
- ☐ Headaches
- ☐ Migraines
- ☐ Dizziness
- ☐ Fainting
- ☐ Stress
- ☐ Depression
- ☐ Learning Disability
- ☐ Anxiety
- ☐ Mental health concerns

Digestion: Eating & Elimination

- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Abnormal Appetite
- ☐ Nausea
- ☐ Abdominal Cramps
- ☐ Vomiting
- ☐ Black or Bloody Stool
- ☐ Diarrhea
- ☐ Constipation
- ☐ Weight gain or loss
- ☐ Other ________________

Please describe:

Heart & Lung Health

- ☐ Stroke
- ☐ Heart Problems
- ☐ Chest Pain
- ☐ Blood Pressure Problems
- ☐ Shortness of Breath
- ☐ Lung Problems or Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Asthma
- ☐ Other ________________

Please describe:

Eyes, Ears, Nose & Throat

- ☐ Vision Problems
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose
- ☐ Sinus Problems
- ☐ Dental Problems
- ☐ Ringing in ears
- ☐ CPAP Machine
- ☐ Other ________________

Please describe:

Bones & Joints

- ☐ Difficulty Chewing
- ☐ Jaw Clicking
- ☐ Neck Pain
- ☐ Back Pain
- ☐ Joint Pain or Stiffness
- ☐ Walking Problems
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Tight Muscles
- ☐ Other ________________

Please describe:

Reproductive and Urinary Health

- ☐ Bladder Trouble
- ☐ Painful or Excessive Urination
- ☐ Discolored Urine
- ☐ Sexual Dysfunction or concerns
- ☐ Incontinence - Bladder
- ☐ Incontinence - Bowel
- ☐ Prostate concerns
- ☐ Other ________________

Please describe:

Women Only:

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain or Infections
- ☐ Breast Pain or Lumps
- ☐ Menopause

When was your last period?

Are you pregnant?
Yes No Not Sure

Family History

- ☐ Heart Disease
- ☐ Diabetes
- ☐ Cancer
- ☐ Alzheimer's
- ☐ Mental Illness
- ☐ Respiratory Disease
- ☐ Stroke
- ☐ Arthritis
- ☐ Kidney Disease
- ☐ Other ________________

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Email Consent

Under Canada's Anti-Spam Legislation (CASL) we are required to gain permission in sending electronic messaging.

I consent to receiving:

- ☐ full circle's email notifications and events
- ☐ Appointment reminders though email
- ☐ Appointment reminders through text – if you choose this please put your cell phone number and your provider in the space provided (e.g. Telus, Bell, Rogers…)

Cell phone # ________________________ Provider ______________________________

*you may choose a combination of text and email as well, please check both boxes and provide the correct information for your cell phone.

_________________________________ _______________
Signature Date

Newsletters include an option for opting out at any time and appointment reminders can be discontinued by calling the office at 587-352-9199.