SOURCE CENTRE
HEALTH IN WHOLENESS

Dr. Allison Barriscale ∞ (416) 728-7365 ∞ sourcecentre.ca
326 Adelaide Street West, Suite 202, Toronto, ON, M5V1R3

Last Name: _____

First Name : _____

Address : _____

City/Prov: _____ **Postal Code :** _____

Best phone number to reach you at: _____**Cell/Home/Work**

2nd Best number to reach you at : _____ **Cell/Home/Work**

Can we leave a message at best number? Y ☐ N ☐ 2nd best? Y ☐ N☐

E-mail Address :_____

Would you like to receive our Source Centre Email Newsletter? ☐ Y☐ N

Date of Birth (mm/dd/yy) :____/____/____ **Gender:**_____

Marital Status :

Single ☐ Coupled ☐ Married/Common Law ☐ Divorced ☐ Widowed ☐

Please list spouse/partner children (same or different address) and others living at the same address

First Name	Last Name	Age	Relationship	Same Address?

Occupation/Title:_____ **Who is your current employer?**_____

How did you find out about Source Center or from whom? _____

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What is your present motivation for consulting our office?

- ☐ Heal disease, symptoms and infirmities
- ☐ Preventing disease, symptoms and infirmities
- ☐ Improving family and/or community health
- ☐ Maximizing personal health potentials

Medical History

Date and reason for last visit to medical doctor: (symptoms, diagnosis, treatment, outcome)

_____

Please list any current medications/supplements that you are currently taking

_____

Please list any medications used in the past for more than three months and their purpose

_____

Have you or anyone in your extended biological family had any previous significant health issues? (i.e. heart disease/stroke, cancer, diabetes, infections) ? Please describe and indicate relationship.

_____

Current Concerns

What is your reason for seeking our services? _____

What concerns do you have about your health and well being? Please list in order of importance.

_____

_____

Please answer the following questions ONLY with respect to your MOST important concern:

In what part of your body do you experience your pain/symptoms? _____

Does your pain/symptom travel to anywhere else in your body? Y ☐ N ☐

If Yes, where? _____

What does this pain/symptom feel like? Please check any that apply:

Sharp ☐ Stabbing ☐ Dull ☐ Achy ☐ Numbness ☐ Tingling ☐ Burning ☐

Cold ☐ Pins & Needles ☐ Electricity ☐ Other (specify): _____

When did this pain/symptom begin? _____

What happened? _____

How has the pain/symptom changed over time? Worse ☐ Better ☐ No Change ☐

How often does this pain/symptom occur? _____

When your pain/symptom is present, how long does it last? _____

On the scale below, please mark the level of pain you most consistently feel, with 0 being no pain and 10 being the worst pain you can imagine.

|_____|

0 **10**

What makes this pain/symptom better? _____

What makes this pain/symptom worse? _____

Are there any other related or associated concerns? _____

Have you ever experienced this pain/symptom or something similar in the past? Y ☐ N ☐

If Yes, please describe _____

Have you sought advice or treatment from a health professional? Y ☐ N ☐ If Yes, what were you told? _____

What was done? _____ **Did it seem to work? Y ☐ N ☐**

History of Stresses

Please indicate any of these that apply to you.

Show past stressors by <u>underlining</u>, show current ones by (circling).

Traumatic Events

Slips Falls Car Accidents Injury Broken Bones/Fractures Surgeries Sprains Contact Sports

Repetitive Stressors

Lifting Bending Carrying Computer work Standing/Sitting for long periods Long drives

Chemical Stressors

Smoking 2nd Hand Smoke Vaccinations OTC Drugs Recreational Drugs Alcohol Caffeine

Refined Sugar Artificial Sweeteners Occupational Environmental Substance Abuse

Mental/Emotional Stressors

Relationships Family Children/Dependants Emotional/Sexual Abuse Divorce/Separation

Loss of loved One Change in Residence Change in Career Work School Fast-paced Life

Internalized Feelings Quick Temper Perfectionist Procrastinator Financial Illness

Birth History

Home ☐ Hospital ☐ Forceps ☐ Caesarean section ☐ Other Trauma: _____

Health and Lifestyle

Is there anything about your Nerve System and Spine that we should know about? What are your concerns? _____

Have you been to a Chiropractor before? Y ☐ N ☐ If Yes, when, why did you go, what was done, what did you enjoy about your experience? _____

Please indicate your participation in the following vehicles of growth, healing and development:

Show past participation by underlining and current participation by circling.

Chiropractic massage yoga pilates chelation homeopathy naturopathy acupuncture ayuvrvedic medicine Qi Gong Tai Chi meditation music therapy herbalist psychotherapy rebirthing breathwork movement therapy energywork nutritional therapy osteopathy prayer church cranial work herbs supplements

When stressed, how do you ìcentreî yourself or ìre-groupî? _____

Is there some aspect of your life that very much pleases you, brings you joy or helps you to feel good about yourself? _____

On a scale of 1 (Low) to 10 (High), please rate the following:

Current Life Stress _____ **Level of Health** _____ **Overall Life Happiness** _____

How many hours of sleep do you get? _____ **What is the quality? Low ☐ Med ☐ High ☐**

Please rate your:	Great	OK	Dissatisfied
Ability to Fall Asleep	☐	☐	☐
Experience of Vitality	☐	☐	☐
Alertness and Clarity	☐	☐	☐
Level of Energy	☐	☐	☐

Yesterday, what did you choose to eat for Breakfast? _____ **Lunch?** _____

Snack? _____ **Dinner?** _____**What is your daily fluid intake?** _____

Please rate your:	Great	OK	Dissatisfied
Mental Focus and Concentration	☐	☐	☐
Weight and Body Image	☐	☐	☐
Digestive Function	☐	☐	☐
Bowel Movement and Urination	☐	☐	☐

How much or what kind of physical activity do you get? _____
Are you training? Y ☐ N ☐ If Yes, please explain _____
What type of work do you do, activities and responsibilities
_____

Please rate your:	Great	OK	Dissatisfied
Balance, Coordination	☐	☐	☐
Physical Flexibility	☐	☐	☐
Physical Endurance	☐	☐	☐
Physical Strength	☐	☐	☐

What do you do for play and relaxation? _____

When was your last vacation? _____

Please rate your:	Great	OK	Dissatisfied
Time for Self	☐	☐	☐
Work and Career Financial	☐	☐	☐
Situation Connectedness	☐	☐	☐
with Others Intimate	☐	☐	☐
Relationship(s)	☐	☐	☐

Your Needs and Hopes for Care

In a published study of over 2,800 participants in Network Spinal Analysis, the participants reported an overall improvement in several categories of health and wellness listed below.

Please indicate how you hope to benefit from care in this office:

	Definitely	Would be Nice	Unimportant
Improvement of physical symptoms	☐	☐	☐
Improvement of emotional/mental symptoms	☐	☐	☐
Improvement of my ability to react/respond to stress	☐	☐	☐
Improvement in enjoyment of life/ ability to make constructive choices	☐	☐	☐
Overall improved quality of life	☐	☐	☐

What is your commitment to yourself, your life and well-being on a scale of 1 to 10, where 1 is no commitment and 10 is ìwill do whatever it takesî? _____

Are there particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook etc. that you feel may *impair* your opportunity for full vitality and health? _____

Are there any factors and elements mentioned above that you feel *give you an edge or add* to your health? _____

Is there anything else that may help in understanding you, your history or your professional needs which have not been discussed on this survey? _____

_____

Thank you for completing these forms and for choosing the Source Center!

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SOURCE CENTRE GENERAL POLICIES

On your first visit, it is required that you fill out health history forms which should be updated yearly with any address or health changes that your practitioner should be aware of. Your practitioner will review this information with you and ask questions to ensure that you receive the treatment that meets your needs. Ongoing progress reports will be attached to your file on a regular basis.

Cancellation/Missed Appointment Policy

If you are unable to make an appointment, we request that you call 24 hours in advance. If you do not call to cancel or if you do not show up for your appointment, a cancellation fee will be charged. The fee for cancellations is equal to 50% the normal rate. If you book within the 24hr time frame, this policy becomes effective immediately. ***All cancellation fees are subject to HST.*

Lateness Policy

Your appointment reserves the specified time for your visit (60 minutes, 90 minutes etc.). If you arrive late for your appointment, you will be charged the full amount of your booked appointment but only receive treatment equal to the time remaining.

Cell Phones/Pagers within the Centre

Please understand that to achieve an environment of quiet and relaxation we ask that you turn off your cell phone, pager or other electronic devices.

Email Etiquette and Consent

We strive to keep in touch with our clients by all media available, the most common of which being Email. We ask that you keep the following in mind when using email to communicate with us:

1. E-mail is not appropriate for urgent or emergency problems, including last minute cancellations.
2. E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that passes through their systems.
3. E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee. If you do not receive a response, do not assume that we have actually received the message.
4. There is no way to assure the privacy of e-mail on a shared computer or e-mail account.
5. All e-mail correspondence will become a part of your medical record at the clinic.
6. It is extremely important to include your name and the name of your practitioner on every e-mail sent to the Source Centre.

By signing this document, you are confirming that you have read and understood the above information about the use of email to communicate matters pertaining to your health and healthcare, and understand the issues inherent in this use.

Consent to Terms of Services (Summary)

Providing you with the highest level of service is our business and we take this very seriously. Please take a minute to review our Terms of Services on our website so you are aware of what you may expect from us. In order for us to ensure you receive the highest level of care, we ask that you respect these Terms.
http://www.sourcecentre.ca/about/more/terms-service/

Privacy Policy Consent

As of January 1st, 2004, the Canadian Federal Government's Personal Information Protection and electronic Document Act (PIPEDA), was created. This privacy law requires your knowledge and consent before we may collect your personal information, except in rare circumstances. This means we want you to understand what we do with personal information we obtain about you. Our full Privacy Policy is available at your request and is posted on our web site at http://www.sourcecentre.ca/about/more/privacy/

Collection of Personal Information (Summary)

In order to provide you a health service we must collect some personal information, including but not limited to: telephone number, address, occupation, health history, prescriptions, involvement in other healthcare, etc. This information will be kept strictly confidential and will not be disclosed to any third party with the exception of the following: with your direct written consent, a medical emergency while you are on the premises, when required by law (i.e. court subpoena) or during regulated healthcare assessment purposes for quality assurances.

Please review our full Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and your right to review your personal information. If you have any questions or concerns about the Privacy Policy, it is your responsibility to address them immediately with your practitioner.

Sharing of Personal Health Information with other Source Centre Practitioners

I consent to Source Centre practitioners, whose care I am under, sharing personal health information amongst themselves with regards to my care, for the purpose of enhanced clinical outcomes Y ❍ N ❍

By signing this Source Centre General Policy form, you are indicating that you have read and consented to all of these policies and that you have had a chance to read, and agree to, our Privacy Policy and our Terms of Service. If there is anything you do not understand in any of the above, please talk to us immediately.

I agree that I have read and understood all the policies, and I have been given a chance to ask any questions I have about the Privacy Policy and Terms of Services and that they have been answered to my satisfaction.

Signature _____

Client Name _____ Date_____

Signature of parent or Guardian (for anyone under the age of 18):

Signature _____

Guardian/Parent Name _____ Date_____