

# PITT MEADOWS WELLNESS CENTRE



604-465-1624

....experience life!

## PATIENT FORM

### Registration Information

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
(First) (Last)

Do you have Extended Medical Coverage through work? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you on MSP Assistance? If you answered yes: Health Card # \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_  
Month/Day/Year

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home #(\_\_\_\_) \_\_\_\_\_ Work #(\_\_\_\_) \_\_\_\_\_ Cell #(\_\_\_\_) \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### IMPORTANT

**We require a minimum of 24 hours notice for appointment cancellations in order to fill those appointment times. A \$25 cancellation fee will be charged for all missed appointments that have not given 24 hours notice.**

# PITT MEADOWS WELLNESS CENTRE



604-465-1624

....experience life!

## ADULT PATIENT HEALTH HISTORY

We appreciate you taking the time to complete this form. All information is confidential. This form will be kept in your file. Please Print.

**Name:**

### Chief Health Concerns

What are your health concerns at this time?

---

### Medical History

How would you describe your general state of health? Excellent Good Fair Poor

Have you had any serious conditions, illnesses, injuries, and/or hospitalizations in the past?

---

Do you have any allergies (medicines, environmental, foods)?

---

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics), with dosage:

---

Please list any past prescription medications:

---

Approximately how many times have you been treated with antibiotics? \_\_\_\_\_

Do you get regular screening visits done by another physician? (Pap, blood tests) Y N

If yes, may we contact the physician to get a copy of those tests? Y N

Doctors Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Do you frequently use any of the following?

- Laxatives
- Diet Pills
- Antacids
- Aspirin/Tylenol/Advil
- Caffeine - form and amount/day \_\_\_\_\_
- Alcohol - how much/day or week \_\_\_\_\_
- Recreational Drugs - what and how much \_\_\_\_\_

Please indicate what immunizations you have had:

- DPT (diphtheria, pertussis, tetanus)
- Hepatitis A
- "Flu"
- Tetanus booster
- Haemophilus influenza B
- MMR (measles, mumps, rubella)
- Hepatitis B
- Smallpox
- Polio

Please indicate any adverse reactions you may have had to past immunizations:

---

**Diet**

Do you have food allergies or intolerances?    Y    N    Please List:

---

---

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

---

How many times a day do you eat the following:

Wheat (breads, pastas, etc.) \_\_\_\_\_

Dairy (milk, cheese, yoghurt, etc.) \_\_\_\_\_

Eggs \_\_\_\_\_

Soy \_\_\_\_\_

**Family Health History**

Indicate if a close relative (parent, grandparent, sibling) has had any of the following:

- |                        |                     |                 |
|------------------------|---------------------|-----------------|
| Allergies              | Endometriosis       | Osteoporosis    |
| Artificial Heart Valve | Gallstones          | PMS             |
| Arthritis              | Heart Disease       | Rubella         |
| Asthma                 | High Blood Pressure | Rheumatic Fever |
| Cancer (type _____)    | Kidney Disease      | Skin Disease    |
| Diabetes               | Mental Illness      | Stroke          |
| Eczema                 | Multiple Sclerosis  | Tuberculosis    |

Any other medical conditions: \_\_\_\_\_

**Environment**

Occupation \_\_\_\_\_

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)?

Please Describe:

---

How would you describe the emotional climate of your home?

---

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

---

Is there anything that you feel is important that hasn't been covered?

---

---

---

# PITT MEADOWS WELLNESS CENTRE



604-465-1624

...experience life!

## INFORMED CONSENT FORM - PROLO/NEURAL THERAPY

I, \_\_\_\_\_, have been advised and consulted about the injection techniques of Prolotherapy, Neural Therapy and Trigger Point Injections.

I have been advised that Prolotherapy is an established technique for tightening of the ligaments. The technique requires the injection of local anesthetic (Procaine or Lidocaine), concentrated sugar water or dextrose, on occasion, Sodium Morrhuate (highly refined cod liver oil) into the ligament. The site of the injection is where the ligaments attach to the bones.

I have been informed that the procedure has been used on thousands of patients and has proven generally safe. This procedure MAY alter and decrease my pain complaints, but may not completely eradicate them.

I have been informed that the alternatives to Prolotherapy are:

1. Doing nothing.
2. Surgical intervention may be a possibility.
3. Injections with steroid may also be helpful but not give lasting results.
4. Continued manipulation may be helpful.

I have been informed that the risks and complications of Prolotherapy are:

1. Immediate pain at the injection site.
2. Allergic reaction to the anesthetic.
3. Spinal cord injury during back injections.
4. Pneumothorax – air on the outside of the lung.
5. Infection at the injection site.
6. Injury to the nerves and muscles at the injection site.
7. Temporary or permanent nerve paralysis.
8. There may be no effect from the treatment.

I have been informed that the risks of NO Prolotherapy are:

1. No relief of pain.
2. Continued degeneration of the joints adjacent to the ligament laxity.

I have been advised that Neural Therapy and Trigger Point Injections are injection techniques frequently used to help patients with long standing pain. These techniques require the injection of local anesthetics (Procaine or Lidocaine), and occasionally homeopathic compounds are injected at the same time. The injections are into both old and new scars. I understand that this technique has been used for many years in Europe and South America and has proven to be useful in treating pain.

I have been informed that the alternatives to Neural Therapy are:

1. Doing nothing.
2. Chemical anesthesia, or strong drugs such as Codeine, Morphine, Demoral – There is a high risk of addiction to these drugs.

I have been informed that the risks of Neural Therapy and Trigger Point Therapy are:

1. Allergic reaction to the local anesthetic.
2. Pain at the injection site.

I have been informed of the risks of NO Neural Therapy:

1. Continued pain and somatic dysfunctions.

I hereby sign that I have read the information on Prolotherapy, Neural Therapy and Trigger Point injections on this page and that I give my consent for these treatments.

\_\_\_\_\_  
Signature of Patient or Person with Authority to Consent for Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date