

Drs. David and Jannice Bowler
4955 Prospect lake Rd
Victoria BC V9E 1J5
Tel: 778-406-0077

Dear Patient,

We look forward to meeting you at your upcoming appointment. Please take a few minutes to print off the attached forms, fill them out and bring them to your appointment, along with your Care Card.

Directions to our office can be found on our website, www.bowlermedical.ca, along with other useful information. Please allow ample travel time, as our location is on a rural, winding road. We are a 20-minute walk to the nearest (infrequent) bus route, so public transportation is not a practical option. If you don't drive, please see if you can arrange for someone to bring you.

We want to make sure you have all the information you need prior to your appointment, so please read through the details below.

Forms to bring to your first appointment: attached to this new patient package are forms we ask you to complete prior to your appointment.

Medical History: please fill this form out as completely as possible

Pain Diagram: please use a coloured marker (eg. a sharpie) to highlight the areas of pain.

Brief Pain Inventory: please answer ALL the questions. You do not need to add up your score – we will do this at the office.

Pain Catastrophizing Scale: please rate each item 0 – 4, with 0 being “not at all” and 4 being “all the time”, based on how you feel when you are in pain. You do not need to add up your score – we will do this at the office.

Patient Health Questionnaire (PHQ-9): Please complete this form but you do not need to add up your score – we will do this at the office.

Consent to Treatment: Please do NOT sign this form ahead of time: we need to witness your signature.

Cancellation policy: we require **48 hours' notice** should you need to reschedule an appointment. A cancellation fee of \$150 for an initial appointment/consultation, and \$75 for a follow-up appointment may be charged in the event of short-notice cancellations if we are unable to fill your appointment time.

Receipts: some of our treatments are uninsured MSP services (such as prolotherapy or platelet-rich plasma, or providing medications and injected solutions for your treatment). You will be informed of any such fees beforehand, and you will be given a receipt for tax purposes at each such visit. Please KEEP these receipts! It takes staff time and administrative costs to re-issue these, and we charge \$25 to re-issue them or \$55 should you require a letter with your visits

and treatments recorded. If you keep your receipts they should be sufficient for your book-keeping and for tax purposes.

Clothing: for your appointment, we ask that you wear loose/stretchy clothing, and if you have long hair please bring a hair elastic with you. If you are having treatment for your neck or upper back, please don't wear ear-rings or necklaces/neck chains. For knee problems, wear or bring shorts, and bring a tank top or sports bra for shoulder/neck/upper back pain.

Timing: please bring your completed forms to your visit, or plan to arrive 15 minutes ahead of time to allow for these forms to be completed at our office for your initial appointment. For other visits, you may be asked to complete a pain score and this can be done beforehand and brought with you, or you can do this if you arrive a few minutes early. The initial visit is booked as a consultation and is 45 minutes. Treatment is only done at the first visit if time permits.

Information about treatments: We have a lot of information about treatments on our website, www.bowlermedical.ca, so please take a look especially at our FAQ page. We also list useful resources such as books to read under the links tab. We encourage questions and love to exchange information with you.

Privacy: we do provide a few chairs outside the office should the weather be nice enough to sit there, and have a small waiting room inside (so please limit the number of people with you.) Please do not walk elsewhere on the property, for our privacy and also for the privacy of the patients we are treating ie. you!

Pets: we kindly ask that you do not bring pets to your visit, and please do not walk your pet on our property, with the exception of service dogs. Even though our office is in a non-commercial area, we ask that you and anyone accompanying you respect that the property is also our home and private yard, and we have our own pets. If you must bring an animal with you, leave time to run them at one of the nearby parks prior to your visit as you will need to leave them in your vehicle here (with the windows open!)

If anyone accompanying you wants something to do, please note the following nice places nearby:

- Mosi's (a popular café 2 km up the road)
- Red Barn (a little way north on West Saanich road – deli for lunches)
- Whitehead Park (corner of Goward and Prospect Lake roads)
- South Prospect Lake Park (southwards on Prospect Lake Rd)
- A little further away is Oldfield Rd which has lovely farm stalls and a winery.

We thank you for your cooperation! Please contact us with any questions or concerns.
The staff at Bowler Medical Clinic.

BOWLER MEDICAL CLINIC – MEDICAL HISTORY AND INFORMATION

Last Name:

First Name:

Emergency Contact, Name and Phone #:

Date of Birth:

Height:

Weight:

Allergies:

Alcohol Use (drinks per week)

Tobacco (cigarettes per day)

Recreational Drug use:

Medications (list any medications you take for pain, as well as prescription medications and supplements):

Medical Conditions (please tick any that apply):

<input type="checkbox"/> High blood Pressure	<input type="checkbox"/> Thyroid condition
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Stroke	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Kidney disease (specify)	<input type="checkbox"/> Neurological disease (specify)
<input type="checkbox"/> Liver disease (specify)	<input type="checkbox"/> Arthritis (specify type)
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Polymyalgia
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Lupus
<input type="checkbox"/> Cancer (specify)	<input type="checkbox"/> Sjogren's disease
<input type="checkbox"/> Stomach ulcer	<input type="checkbox"/> Bleeding or clotting disorder
<input type="checkbox"/> Reflux	<input type="checkbox"/> Immune disorder
<input type="checkbox"/> Irritable Bowel Syndrome	<input type="checkbox"/> Other (list below):
<input type="checkbox"/> Crohn's disease	
<input type="checkbox"/> Ulcerative Colitis	
<input type="checkbox"/> Skin condition (specify)	

Surgeries (list any you have had and dates if possible):

Fractures (list any you have had and dates if possible):

Injuries (Briefly list any you have had and if they cause on-going concerns):

Where are you experiencing pain (ie: left knee):

Treatments I have tried for pain (please tick any that apply):

<input type="checkbox"/> Physiotherapy	<input type="checkbox"/> Yoga
<input type="checkbox"/> Chiropractic	<input type="checkbox"/> Acupuncture
<input type="checkbox"/> Massage	<input type="checkbox"/> Aquasize
<input type="checkbox"/> IMS	<input type="checkbox"/> Gym Workouts
<input type="checkbox"/> TENS	<input type="checkbox"/> Other (list):
<input type="checkbox"/> Shockwave Therapy	
<input type="checkbox"/> Kinesiology	

Exercise or Sport (What types and how often)

Is this visit ICBC related? Yes No

If yes, please provide the following:

Claim #:

Adjuster's name:

Adjuster's phone:

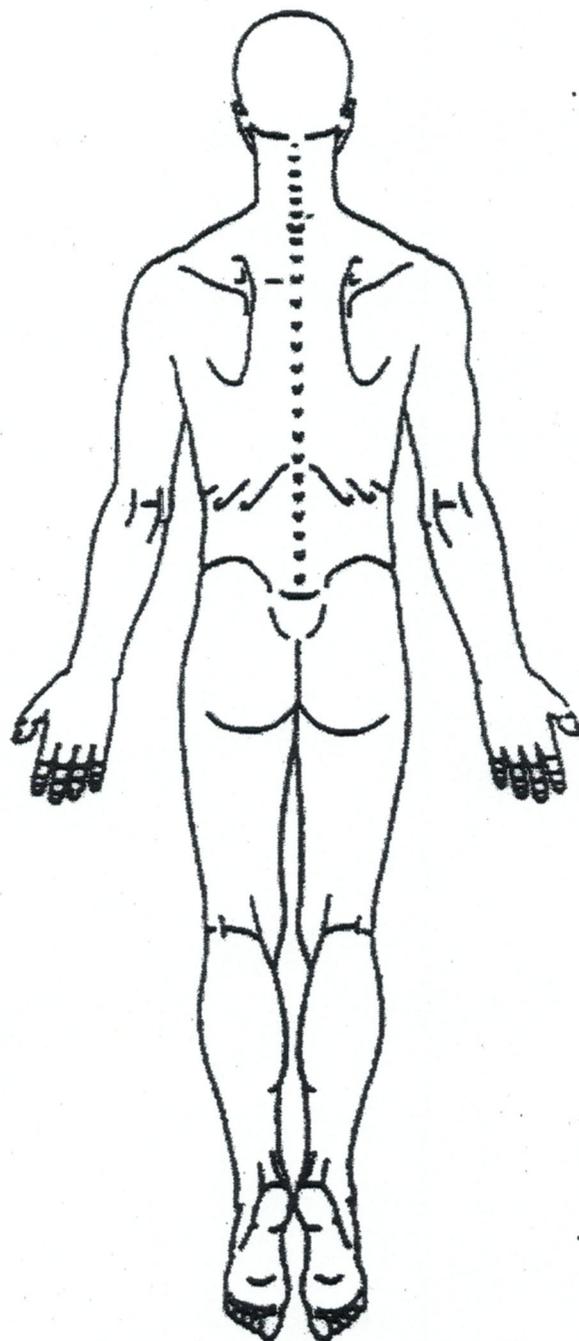
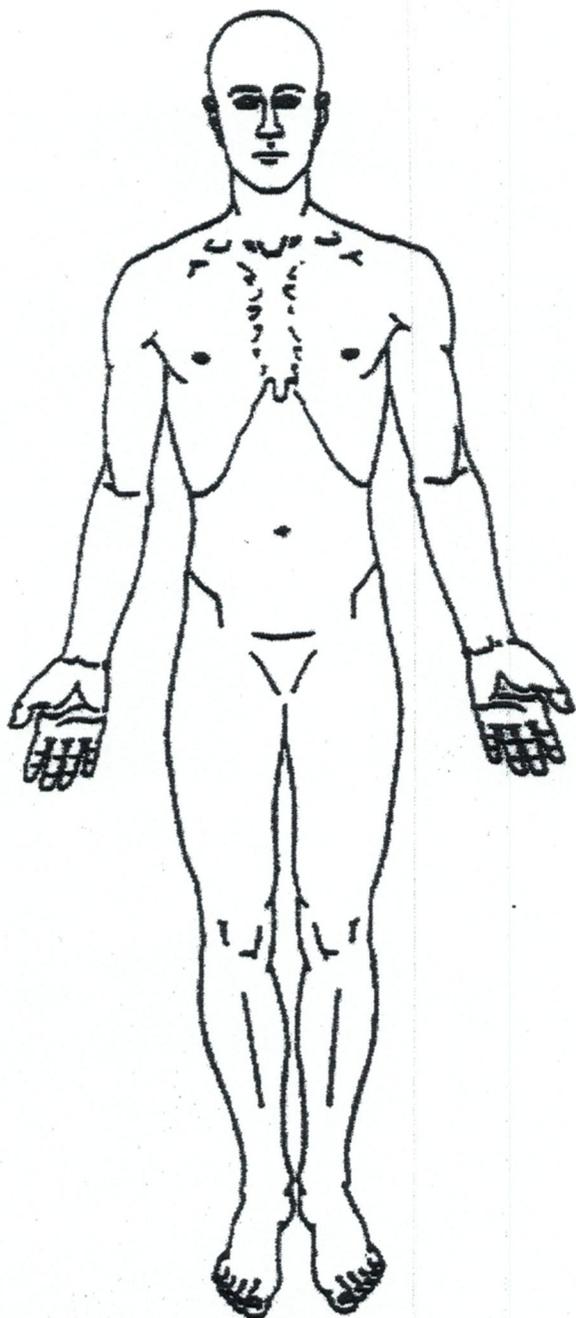
Adjuster's fax:

Lawyer's name and firm (if applicable for your ICBC claim):

Is this visit WSBC related: Yes No

Claim #

PLEASE CLEARLY MARK THE LOCATIONS OF PAIN



NAME:

DATE OF BIRTH:

Pain Catastrophizing Scale

Sullivan MJL, Bishop S, Pivik J. (1995)

Name: _____

Age: _____

Gender:

Date: _____

Male Female

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

Instructions:

We are interested in the types of thoughts and feelings that you have when you are in pain. Listed below are thirteen statements describing different thoughts and feelings that may be associated with pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you are experiencing pain.

RATING	0	1	2	3	4
MEANING	Not at all	To a slight degree	To a moderate degree	To a great degree	All the time

When I'm in pain ...

Number	Statement	Rating
1	I worry all the time about whether the pain will end.	
2	I feel I can't go on.	
3	It's terrible and I think it's never going to get any better	
4	It's awful and I feel that it overwhelms me.	
5	I feel I can't stand it anymore	
6	I become afraid that the pain will get worse.	
7	I keep thinking of other painful events	
8	I anxiously want the pain to go away	
9	I can't seem to keep it out of my mind	
10	I keep thinking about how much it hurts.	
11	I keep thinking about how badly I want the pain to stop	
12	There's nothing I can do to reduce the intensity of the pain	
13	I wonder whether something serious may happen.	

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____

DATE: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

add columns + +

(Healthcare professional: For interpretation of TOTAL, TOTAL:
please refer to accompanying scoring card).

<p>10. If you checked off <i>any problems</i>, how <i>difficult</i> have these problems made it for you to do your work, take care of things at home, or get along with other people?</p>	<p>Not difficult at all _____</p> <p>Somewhat difficult _____</p> <p>Very difficult _____</p> <p>Extremely difficult _____</p>
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PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.

Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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BOWLER MEDICAL CLINIC
Consent to Treatment

I, _____,

consent to the following treatment:

- Trigger point injections
- Prolotherapy injections
- Ultrasound-guided joint injection(s)
- Perineural/Neural prolotherapy injections
- Caudal epidural
- Peripheral nerve block
- Platelet-rich plasma (PRP)

Dr. Jannice or David Bowler has explained the potential risks and benefits. I understand the complications might include bruising or bleeding/oozing (stops with pressure), post-injection tenderness or post-treatment “stiffness”, infection (rare), pneumothorax (very rare), temporary numbing, nausea and light-headedness.

Signed

Witness: Signed

Print name

Print name

Date
