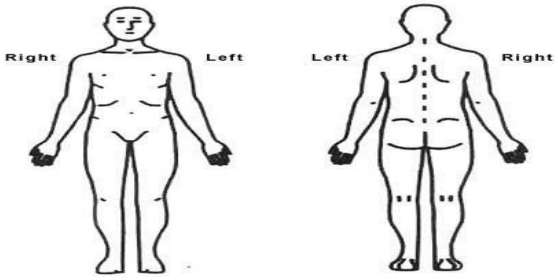
INTELLIGENT HEALTH GROUP

Patients Name: _____

EHC/PRIVATE PATIENT INTAKE FORM

Name		**DOB (dd/mm/yy)**		**How did you hear about us?**	
Address				City:	Postal Code:
Contact #'s	Home:	Mobile:		Email:	
Occupation		**Status**	❑ Single ❑ Divorced	❑ Married ❑ Separated	❑ Common Law ❑ Widowed
Emergency Contact		Relationship:		Phone:	
Family MD	Name: Phone:	Can we send your MD a progress report? ❑ Yes ❑ No			
Do we have your permission to add you to our email list and SMS for appointment confirmations, reminders, updates, monthly health newsletters and general correspondence? (Circle) Yes No					

Do you have any of the following symptoms?	❑ Pain/Discomfort ❑ Swelling ❑ Spasm ❑ Numbness/Tingling ❑ Stiffness ❑ Weakness ❑ Headaches ❑ Migraines	❑ Dizziness/Fainting ❑ Nausea/Fever ❑ Fatigue ❑ Digestive problems ❑ Urination problems ❑ Bowel problems ❑ Sexual dysfunction ❑ Numbness in buttocks	❑ Anxiety/Panic attacks ❑ Depression ❑ Insomnia ❑ Acid reflux/Ulcers ❑ Blood urine ❑ Weight loss/gain ❑ Night sweats ❑ Allergies
Do you, or have you ever had?	❑ Osteoporosis ❑ Arthritis ❑ Rheumatoid Arthritis ❑ Ankylosing Spondylitis ❑ Spinal Infection ❑ Diabetes ❑ Cancer ❑ Epilepsy	❑ Heart Attack ❑ Heart Disease/Pacemaker ❑ High Cholesterol ❑ High Blood Pressure ❑ Stroke/TIA/Aneurysm ❑ Blood Clots ❑ Abdominal Aortic Aneurysm ❑ Angina	❑ Respiratory Disease ❑ Asthma/Chronic Bronchitis ❑ Thyroid disease/problems ❑ Kidney disease/problems ❑ Liver disease/problems ❑ Skin problems ❑ Psychological disorder ❑ Fibromyalgia/Chronic Fatigue
Where is your pain? ***Use the diagram to indicate your problem areas***			**On a scale of 0 to 10, with 0 being no pain and 10 being excruciating pain, where is your pain?** **0 1 2 3 4 5 6 7 8 9 10**

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HEALTH HISTORY

What Treatment have you had?	❑ Chiropractic ❑ Physiotherapy ❑ Massage Therapy ❑ Medical Consult Only ❑ Medication Only ❑ Traditional Chinese Medicine ❑ Acupuncture ❑ Naturopathy ❑ Osteopathy ❑ Homeopathy ❑ Other:	**What tests have you had?**	❑ Blood Work ❑ X-rays ❑ MRI ❑ CT Scan ❑ Bone Density ❑ Ultrasound ❑ ECG/EMG ❑ Nerve conduction tests ❑ Recent Physical ❑ Recent Pap / Mammogram (women)
What do you feel caused your problem?	❑ Trauma/injury ❑ Car accident ❑ Stress related	❑ Work injury ❑ Sports injury ❑ Unknown	
What do you hope to achieve from your visit today?	❑ Answers ❑ Solutions	❑ Symptom relief ❑ Improved health	❑ Wellness and prevention ❑ Maintenance care

Medical History: ***Please complete it as thoroughly as possible.***			
Significant Surgeries	❑ None	❑ Yes	List:
Fractures / Injuries	❑ None	❑ Yes	List:
Significant Accidents / Falls	❑ None	❑ Yes	List:
Medications / Vitamins	❑ None	❑ Yes	List and describe what you are taking it for:

Do you have a family history of any of the following?

❑ Cancer	❑ Heart disease	❑ Depression	❑ Kidney disease
❑ Obesity	❑ High blood pressure	❑ Anxiety disorders	❑ Liver disease
❑ Diabetes	❑ High cholesterol	❑ Alzheimer's	❑ Digestive disorder
❑ Osteoporosis	❑ Stroke	❑ Parkinson's	❑ Thyroid disorder
❑ Arthritis	❑ Blood disorders	❑ Huntington's	❑ Mental illness

I hereby give permission for Intelligent Health Group to review the above documentation and perform consultation and examination which may include: posture screen, gait analysis, biomechanical analysis, range of motion testing, orthopedic tests, neurological assessment and if required a referral for x-rays or other diagnostic test.

Patient's Signature: _____ **Date:** _____

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INSURANCE INFORMATION

Extended Health Care Information			
Do you have Extended Health Care Coverage	❑ Yes	❑ No	If indicated yes, a form will be given to you from the front desk to fill out.
Does your spouse have Extended Health Care Coverage?	❑ Yes	❑ No	
Do your parent(s) have Extended Health Care Coverage?	❑ Yes	❑ No	

NEEDS ASSESSMENT

Do you feel bodily aches and pains?	❑ Yes	❑ No
Have you ever been involved in a motor vehicle accident, slip, and fall or workplace injury?	❑ Yes	❑ No
Do you ever feel overwhelmed and not in control of a situation?	❑ Yes	❑ No
Are you able to consistently manage stress in your life?	❑ Yes	❑ No
Do you feel your diet can be improved in any way?	❑ Yes	❑ No
Do you tend to lack energy or feel tired?	❑ Yes	❑ No
Do you ever experience digestive problems?	❑ Yes	❑ No
Would you benefit from any positive parenting tips?	❑ Yes	❑ No

Please indicate the frequency of use of the following daily:			
Cigarettes/cigars		**Pain relievers**	
Coffee		**Recreational drugs**	
Tea		**Pop**	
Alcohol		**Water**	

Sleep:			
# of hours of sleep		What is your quality of sleep?	

Stress:			
How would you rate your stress level? (0-100)		What is your main cause for stress?	

Would you be interested in a free consultation with any of the following practitioners?

- ❑ Chiropractor
- ❑ Physiotherapist
- ❑ Registered Massage Therapist
- ❑ Traditional Chinese Medicine Practitioner (Acupuncture, cupping and massage)
- ❑ Holistic Treatment Practitioner (Emotion Code, Touch for Health, Access Bars or Reiki)
- ❑ Naturopath
- ❑ Iridologist
- ❑ Psychotherapist

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NO SHOW FEE POLICY

As you can understand, when a patient fails to keep an appointment, professional time goes unused and other patients fail to receive timely care.

Please note that Intelligent Health Group has a no-show policy for all missed appointments without 24 hours' notice.

SERVICE	**CANCELLATION FEE**
Chiropractic Treatment	$25
Physiotherapy Treatment	Full Appointment Fee
Massage Therapy	Full Appointment Fee
Traditional Chinese Medicine	Full Appointment Fee
Holistic Treatment	Full Appointment Fee
Counselling	Full Appointment Fee
Iridology	Full Appointment Fee

Please be advised that your insurance will not cover any charges for no-show fees.
Your signature below indicates that you understand and have reviewed our no-show policy.

Patient's Signature: _____ **Date:** _____