



Patients Name: _____

EHC/PRIVATE PATIENT INTAKE FORM

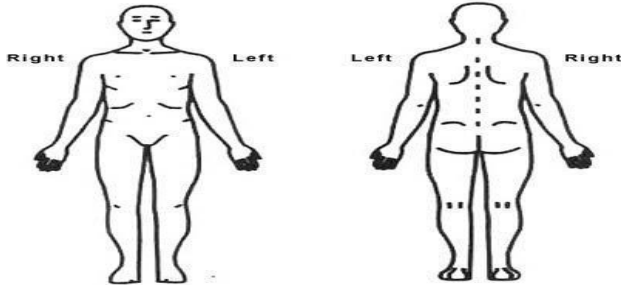
Name		DOB (dd/mm/yy)		How did you hear about us?	
Address				City:	Postal Code:
Contact #'s	Home:	Mobile:	Email:		
Occupation		Status	<input type="checkbox"/> Single <input type="checkbox"/> Divorced	<input type="checkbox"/> Married <input type="checkbox"/> Separated	<input type="checkbox"/> Common Law <input type="checkbox"/> Widowed
Emergency Contact name		Relationship:	Phone:		
Family MD	Name:		Can we send your MD a progress report? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Phone:				
<p>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</p>					

INSURANCE INFORMATION

Extended Health Care Information		
Do you have Extended Health Care Coverage	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does your spouse have Extended Health Care Coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do your parent(s) have Extended Health Care Coverage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If indicated yes, a form will be given to you from the front desk to fill out.		

HEALTH HISTORY

Do you have any of the following symptoms?	<input type="checkbox"/> Pain/Discomfort	<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Anxiety/Panic attacks
	<input type="checkbox"/> Swelling	<input type="checkbox"/> Nausea/Fever	<input type="checkbox"/> Depression
	<input type="checkbox"/> Spasm	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Insomnia
	<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Digestive problems	<input type="checkbox"/> Acid reflux/Ulcers
	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Urination problems	<input type="checkbox"/> Blood urine
	<input type="checkbox"/> Weakness	<input type="checkbox"/> Bowel problems	<input type="checkbox"/> Weight loss/gain
	<input type="checkbox"/> Headaches	<input type="checkbox"/> Sexual dysfunction	<input type="checkbox"/> Night sweats
	<input type="checkbox"/> Migraines	<input type="checkbox"/> Numbness in buttocks	<input type="checkbox"/> Allergies
Do you, or have you ever had?	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Respiratory Disease
	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Disease/Pacemaker	<input type="checkbox"/> Asthma/Chronic Bronchitis
	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Thyroid disease/problems
	<input type="checkbox"/> Ankylosing Spondylitis	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Kidney disease/problems
	<input type="checkbox"/> Spinal Infection	<input type="checkbox"/> Stroke/TIA/Aneurysm	<input type="checkbox"/> Liver disease/problems
	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Skin problems
	<input type="checkbox"/> Cancer	<input type="checkbox"/> Angina	<input type="checkbox"/> Psychological disorder
	<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Fibromyalgia/Chronic Fatigue

Where is your pain? <i>Use the diagram to indicate your problem areas</i>		On a scale of 0 to 10, with 0 being no pain and 10 being excruciating pain, what level is your pain? <p style="text-align: center;">0 1 2 3 4 5 6 7 8 9 10</p>
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What Treatment have you had?	<input type="checkbox"/> Chiropractic <input type="checkbox"/> Physiotherapy <input type="checkbox"/> Massage Therapy <input type="checkbox"/> Medical Consult Only <input type="checkbox"/> Medication Only <input type="checkbox"/> Traditional Chinese Medicine <input type="checkbox"/> Acupuncture <input type="checkbox"/> Naturopathy <input type="checkbox"/> Osteopathy <input type="checkbox"/> Homeopathy <input type="checkbox"/> Other:	What tests have you had?	<input type="checkbox"/> Blood Work <input type="checkbox"/> X-rays <input type="checkbox"/> MRI <input type="checkbox"/> CT Scan <input type="checkbox"/> Bone Density <input type="checkbox"/> Ultrasound <input type="checkbox"/> ECG/EMG <input type="checkbox"/> Nerve conduction tests <input type="checkbox"/> Recent Physical <input type="checkbox"/> Recent Pap / Mammogram (women)
What do you feel caused your problem?	<input type="checkbox"/> Trauma/injury <input type="checkbox"/> Car accident <input type="checkbox"/> Stress related		
What do you hope to achieve from your visit today?	<input type="checkbox"/> Answers <input type="checkbox"/> Solutions <input type="checkbox"/> Symptom relief <input type="checkbox"/> Improved health <input type="checkbox"/> Work injury <input type="checkbox"/> Sports injury <input type="checkbox"/> Unknown <input type="checkbox"/> Wellness and prevention <input type="checkbox"/> Maintenance care		

Medical History: Please complete it as thoroughly as possible.			
Significant Surgeries	<input type="checkbox"/> None	<input type="checkbox"/> Yes	List:
Fractures / Injuries	<input type="checkbox"/> None	<input type="checkbox"/> Yes	List:
Significant Accidents / Falls	<input type="checkbox"/> None	<input type="checkbox"/> Yes	List:
Medications / Vitamins	<input type="checkbox"/> None	<input type="checkbox"/> Yes	List and describe what you are taking it for:

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

<input type="checkbox"/> Cancer	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Other:
<input type="checkbox"/> Obesity	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Depression	
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Anxiety disorders	
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Mental illness	



FUNCTIONAL HEALTH ASSESSMENT

Functional Abilities

The following activities are performed during a typical day. Over the last two days, has your health condition limited you in any of these activities?

Lifting	Yes, limited a lot	Yes, limited a little	No, not limited at all
Stair climbing	Yes, limited a lot	Yes, limited a little	No, not limited at all
Bending or twisting	Yes, limited a lot	Yes, limited a little	No, not limited at all
Housekeeping	Yes, limited a lot	Yes, limited a little	No, not limited at all
Work duties	Yes, limited a lot	Yes, limited a little	No, not limited at all
Caregiving	Yes, limited a lot	Yes, limited a little	No, not limited at all
Recreational Activities	Yes, limited a lot	Yes, limited a little	No, not limited at all
Driving	Yes, limited a lot	Yes, limited a little	No, not limited at all
Social life	Yes, limited a lot	Yes, limited a little	No, not limited at all
Personal Hygiene	Yes, limited a lot	Yes, limited a little	No, not limited at all

Quality of Life

How would you rate your quality of life?

- Very Poor
1 •
- Poor
2 •
- Neither poor nor good
3 •
- Good
4 •
- Very Good
5 •

Physical Health

How would you rate your physical health?

- Very Poor
1 •
- Poor
2 •
- Neither poor nor good
3 •
- Good
4 •
- Very Good
5 •

Mental and Emotional Health

How would you rate your mental and emotional health?

- Very Poor
1 •
- Poor
2 •
- Neither poor nor good
3 •
- Good
4 •
- Very Good
5 •

Diet and Nutrition

How would you rate your diet and nutrition?

- Very Poor
1 •
- Poor
2 •
- Neither poor nor good
3 •
- Good
4 •
- Very Good
5 •

OFFICE USE ONLY

HIS (Health Index Score): Previous: _____ / 50 Current: _____ / 50

NPS (Numeric Pain Scale): Previous: _____ / 10 Current: _____ / 10



Patients Name: _____

NEEDS ASSESSMENT

Do you feel bodily aches and pains?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been involved in a motor vehicle accident, slip, and fall or workplace injury?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you ever feel overwhelmed and not in control of a situation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you able to consistently manage stress in your life?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel your diet can be improved in any way?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you tend to lack energy or feel tired?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you ever experience digestive problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you benefit from any positive parenting tips?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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)
- Registered Dietitian
- Naturopath
- Iridologist
- Psychotherapist

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: _____



Patients Name: _____

OFFICE POLICIES

1. If you ever wish to change your health goal, or associated treatment frequency, you are required to speak to your health professional directly. Our administrators are unable to make changes to your plan as it may affect your health negatively.
2. Our office is dedicated to nurturing a safe, healing environment. As such, any rude, inappropriate, discriminatory, intolerant behavior or language will not be accepted, and as such, may lead to termination of care at our office.
3. Payments for treatments are to be rendered at the end of each session, or prepaid through a payment plan. Unpaid outstanding balances over 30 days past due can be sent to a Collections agency for recovery of payment. Prepaid payment plans may be cancelled at anytime. A refund will be issued based on a re-calculation of the treatments completed at full cost.
4. Direct billing to *only your primary* insurance provider can be arranged, as long as the payments are directly paid to the clinic, and our *Extended Health Benefits Form* has been completed. It is required that *claim forms*, *Consent form*, and an *Assignment of Benefits Form* are signed and kept on record. Co-pay amounts not covered by your insurer must be paid at the time of service. You are required to keep track of your insurance coverage directly.
5. Our office respects each patient's right to privacy and keeps personal information confidential, unless required by law or in the case of a medical emergency. Patient files will remain in our stewardship for a minimum of 7 years after the last patient visit.
7. Our office may give appointment reminder calls, recalls, and reassurance calls. If you do not wish to receive any of these notifications please inform our front desk.
8. If you are unable to keep an appointment, simply call or email us at least **24 hours prior** to your appointment to reschedule. Missed appointments, late cancellations or arrivals will result in a charge for the full appointment fee. Please be advised that your insurance provider, or payment plan, will not cover such fees.

Your signature below confirms that you have reviewed all of these policies, and have had an opportunity to discuss them.

Patient's Signature: _____

Date: _____