INTELLIGENT HEALTH GROUP

Patients Name: _____

MVA 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 and Fax:	Can we send your MD a progress report? ❑ Yes ❑ No			
Do we have your permission to add you to our email list for appointment confirmations, reminders, updates, monthly health newsletters and general correspondence? Yes No					

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	

Automobile Insurance Information					
Insurance Company Name:		City or Town of Branch Office:			
Adjuster's Name		Telephone:		Fax:	
Date of Accident:		Policy #:		Claim #:	
Name of Policy Holder		Were you at fault for the accident?			

Work Information			
Employer:		Job Title:	
Telephone:		Fax:	
Did you take time off work:		Date last worked:	

Legal Information				
Do you have a lawyer for your accident?			❑ Yes	❑ No
If yes, complete below. If not, would you like us to arrange a consultation with a lawyer?			❑ Yes	❑ No
Law Firm:		Telephone:		

INTELLIGENT HEALTH GROUP

Patients Name: _____

ACCIDENT PROFILE

Accident Details			
Were you working the time of the accident? ☐Yes ☐No			
Location of accident?		Type of Vehicle & Year (make, model, year):	
☐Driver ☐Front Passenger ☐Rear Passenger ☐Pedestrian ☐Bicycle # of Passengers in vehicle:			
How did the accident happen? (Put as much detail as possible)			
Were you wearing a seatbelt?	❑ Yes ❑ No	Did the airbags deploy?	❑ Yes ❑ No
What parts of your body did you hit inside the vehicle?			
Did you lose consciousness?	❑ Yes ❑ No	Any nausea or vomiting after the accident?	❑ Yes ❑ No
Did the police arrive?	❑ Yes ❑ No	Was the accident reported?	❑ Yes ❑ No
Did the ambulance arrive?	❑ Yes ❑ No	If yes, were you transported to hospital?	❑ Yes ❑ No
Were you charged for this accident?			❑ Yes ❑ No

Treatment Received from Medical Practitioner		
	Hospital	**Family Physician**
Date:		
Name/Location:		
Name of Doctor:		
Procedures/Examinations:	☐X-ray ☐Exam ☐CT/MRI ☐Ultrasound	☐X-ray ☐Exam ☐CT/MRI ☐Ultrasound Results:
Findings:		
Prescribed Medication:		

Previous Therapy Treatment			
Have you received treatment at any other therapy clinics for this accident?		❑ Yes	❑ No
Name of clinic:			
Start Date:		End Date:	
Type of therapy:	o Chiropractic o Physiotherapy o Massage Therapy o Acupuncture	Frequency	

I hereby certify that all the information recorded is true and accurate.

Patient Signature: _____ **Date:** _____

INTELLIGENT HEALTH GROUP

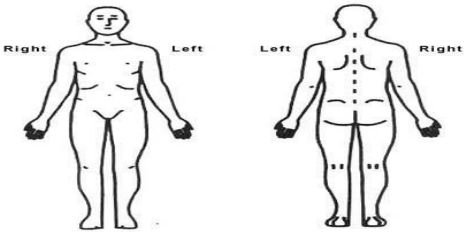
Patients Name: _____

HEALTH HISTORY – 1 of 2

Personal Information							
Age:		Gender:	❑ Male ❑ Female	Height:		Weight:	lbs
Dominant Hand:	❑ Left	❑ Right	What side do you sleep on?				

Personal Devices	Y	N		Y	N		Y	N
Custom orthotics			Heel lifts			Off the shelf orthotics		
Compression stockings			Cervical pillow			Back support		
Orthotic brace/support			Tens			Orthopaedic braces		

Job Information						
Shift:	❑ F/T ❑ P/T	Missed time from work?	o Yes ❑ No	Returned to work?	❑ Yes ❑ No	
Job Duties	❑ Sit ❑ Stand ❑ Walk ❑ Lift ❑ Carry ❑ Push ❑ Pull ❑ Bend ❑ Stoop ❑ Squat ❑ Kneel ❑ Reach ❑ Grip					

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**

INTELLIGENT HEALTH GROUP

Patients Name: _____

HEALTH HISTORY – 2 of 2

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)

Medical History: ***Please complete 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:** _____

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

Physical Health

How would you rate your physical health?

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

Mental and Emotional Health

How would you rate your mental and emotional health?

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

Diet and Nutrition

How would you rate your diet and nutrition?

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

OFFICE USE ONLY

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

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

INTELLIGENT HEALTH GROUP

Patients Name: _____

ACTIVITIES OF DAILY LIVING

Please review the following list carefully. Indicate your pre-accident and post-accident status/abilities with respect to each activity of daily living.

		Pre MVA				Current			
		Able	Partial	Unable	N/A	Able	Partial	Unable	N/A
Mobility	Siting								
	Standing								
	Walking								
	Bending/stooping								
	Squatting/kneeling								
	Reaching								
	Pulling								
	Lifting								
Personal Care Tasks	Dress/undress								
	Showering								
	Hair care								
	Nail/Grooming								
Housekeeping & Home Maintenance	Bedroom cleaning								
	Bathroom cleaning								
	Kitchen cleaning								
	Meal preparation								
	Grocery shopping								
	Dusting								
	Mopping								
	Sweeping								
	Vacuuming								
	Garbage removal								
	Outdoor work								
	Driving								
Childcare/Care giving	Do you have children? ☐Yes ☐No			If yes, how many?			Special needs: ☐Yes ☐No		
	Dress/undress								
	Bathing								
	Feeding								
	Nail/Grooming								
	Homework assist								
	Supervision								
Additional Information:									

Patient Signature: _____ **Date:** _____

INTELLIGENT HEALTH GROUP

Patients Name: _____

NECK DISABILITY INDEX

Section 1 – Pain Intensity _ I have no pain at the moment. _ The pain is very mild at the moment. _ The pain is moderate at the moment. _ The pain is fairly severe at the moment. _ The pain is very severe at the moment. _ The pain is the worst imaginable at the moment.	**Section 6 – Concentration** _ I can concentrate fully when I want to with no difficulty. _ I can concentrate fully when I want to with slight difficulty. _ I have a fair degree of difficulty in concentrating when I want to. _ I have a lot of difficulty in concentrating when I want to. _ I have a great deal of difficulty in concentrating when I want to. _ I cannot concentrate at all.
Section 2 – Personal Care (Washing, Dressing, etc.) _ I can look after myself normally without causing extra pain. _ I can look after myself normally but it causes extra pain. _ It is painful to look after myself and I am slow and careful. _ I need some help but manage most of my personal care. _ I need help every day in most aspects of self-care. _ I do not get dressed, I wash with difficulty and stay in bed.	**Section 7 – Work** _ I can do as much work as I want to. _ I can do my usual work, but no more. _ I can do most of my usual work, but no more. _ I cannot do my usual work. _ I can hardly do any work at all. _ I cannot do any work at all.
Section 3 – Lifting _ I can lift heavy weights without extra pain. _ I can lift heavy weights but it gives extra pain. _ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. _ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. _ I can lift very light weights. _ I cannot lift or carry anything at all.	**Section 8 – Driving** _ I can drive my car without any neck pain. _ I can drive my car as long as I want with slight pain in my neck. _ I can drive my car as long as I want with moderate pain in my neck. _ I cannot drive my car as long as I want because of moderate pain in my neck. _ I can hardly drive at all because of severe pain in my neck. _ I cannot drive my car at all.
Section 4 – Reading _ I can read as much as I want to with no pain in my neck. _ I can read as much as I want to with slight pain in my neck. _ I can read as much as I want with moderate pain in my neck. _ I cannot read as much as I want because of moderate pain in my neck. _ I can hardly read at all because of severe pain in my neck. _ I cannot read at all.	**Section 9 – Sleeping** _ I have no trouble sleeping. _ My sleep is slightly disturbed (less than 1 hour sleepless). _ My sleep is mildly disturbed (1-2 hours sleepless). _ My sleep is moderately disturbed (2-3 hours sleepless). _ My sleep is greatly disturbed (3-5 hours sleepless). _ My sleep is completely disturbed (5-7 hours sleepless).
Section 5 – Headaches _ I have no headaches at all. _ I have slight headaches that come infrequently. _ I have moderate headaches which come infrequently. _ I have moderate headaches which come frequently. _ I have severe headaches which come frequently. _ I have headaches almost all the time.	**Section 10 – Recreation** _ I am able to engage in all my recreation activities with no neck pain at all. _ I am able to engage in all my recreation activities, with some pain in my neck. _ I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. _ I am able to engage in a few of my usual recreation activities because of pain in my neck. _ I can hardly do any recreation activities because of pain in my neck. _ I cannot do any recreation activities at all.

Patient Signature: _____ **Date:** _____

INTELLIGENT HEALTH GROUP

Patients Name: _____

Reviewed By: _____ **Score:** _____

OSWESTRY DISABILITY INDEX

Section 1 – Pain Intensity _ I have no pain at the moment. _ The pain is very mild at the moment. _ The pain is moderate at the moment. _ The pain is fairly severe at the moment. _ The pain is very severe at the moment. _ The pain is the worst imaginable at the moment.	**Section 7 – Sleeping** _ My sleep is never disturbed by pain. _ My sleep is occasionally disturbed by pain. _ Because of pain, I have less than 6 hours sleep. _ Because of pain, I have less than 4 hours sleep. _ Because of pain, I have less than 2 hours sleep. _ Pain prevents me from sleeping at all.
Section 2 – Personal Care (washing, dressing, etc.) _ I can look after myself normally without causing extra pain. _ I can look after myself normally but it causes extra pain. _ It is painful to look after myself and I am slow and careful. _ I need some help but manage most of my personal care. _ I need help every day in most aspects of my personal care. _ I do not get dressed, I wash with difficulty and stay in bed.	**Section 8 – Sex life (if applicable)** _ My sex life is normal and causes no extra pain. _ My sex life is normal but causes some extra pain. _ My sex life is nearly normal but is very painful. _ My sex life is severely restricted by pain. _ My sex life is nearly absent because of pain. _ Pain prevents any sex life at all.
Section 3 - Lifting _ I can lift heavy weights without extra pain. _ I can lift heavy weights but it gives extra pain. _ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table). _ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. _ I can lift only very light weights. _ I cannot lift or carry anything at all.	**Section 9 – Social Life** _ My social life is normal and causes me no extra pain. _ My social life is normal but increases the degree of pain. _ Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports. _ Pain has restricted my social life and I do not go out as often. _ Pain has restricted social life to my home. _ I have no social life because of pain.
Section 4 – Walking _ Pain does not prevent me walking any distance. _ Pain prevents me from walking more than 1mile. _ Pain prevents me walking more than ¼ of a mile. _ Pain prevents me walking more than 100 yards. _ I can only walk using a stick or crutches. _ I am in bed most of the time and have to crawl to the toilet.	**Section 10 – Traveling** _ I can travel anywhere without pain. _ I can travel anywhere but it gives extra pain. _ Pain is bad but I manage journeys of over two hours. _ Pain restricts me to short necessary journeys under 30 minutes. _ Pain prevents me from traveling except to receive treatment.
Section 5 – Sitting _ I can sit in any chair as long as I like. _ I can sit in my favorite chair as long as I like. _ Pain prevents me from sitting for more than 1 hour. _ Pain prevents me from sitting for more than ½ hour. _ Pain prevents me from sitting for more than 10 minutes. _ Pain prevents me from sitting at all.	**Section 11 - Previous Treatment** Over the past three months have you received treatment, tablets, or medicines of any kind for your back or leg pain? Please check the appropriate box. _ No _ Yes (if yes, please state the type of treatment you have received)
Section 6 – Standing _ I can stand as long as I want without extra pain. _ I can stand as long as I want but it gives me extra pain. _ Pain prevents me from standing for more than 1 hour. _ Pain prevents me from standing for more than ½ an hour. _ Pain prevents me from standing for more than 10 minutes. _ Pain prevents me from standing at all.	

Patient Signature: _____ **Date:** _____

Reviewed By: _____ **Score:** _____

INTELLIGENT HEALTH GROUP

Patients Name: _____

PSYCHOLOGICAL SYMPTOMS CHECKLIST

Check all that apply since the motor vehicle accident

Psychological Symptoms	Neurocognitive Symptoms
❑ Sleeping difficulty ❑ Nightmares ❑ Fear of being in a car as a driver ❑ Fear of being in a car as a passenger ❑ Changes in appetite ❑ Having increase stress in relationships ❑ Depression ❑ Persistent sadness ❑ Crying ❑ Tense, worried or nervous ❑ Stressed and anxious ❑ Low energy ❑ Less interest in previously enjoyed activities ❑ Irritable ❑ Frustrated ❑ Outbursts of anger ❑ Persistent thoughts of the accident ❑ Flashbacks of the accident ❑ Difficulty coping with pain ❑ Social phobia ❑ Suicidal thoughts ❑ Racing thoughts ❑ Feeling 'I'm not the same person' ❑ Changes in Libido	❑ Persistent headaches or feeling of pressure ❑ Loss of consciousness ❑ Confusion ❑ Mental slowness ❑ Amnesia surrounding the motor vehicle accident ❑ Dizziness ❑ Ringing in the ears ❑ Nausea ❑ Slurred speech ❑ Difficulty understanding speech ❑ Fatigue ❑ Concentration and memory problems ❑ Personality changes ❑ Unusual seeing problems ❑ Unusual hearing problems ❑ Difficulty finding words ❑ Obsessive thoughts ❑ Sleep disturbance ❑ Psychological adjustment problems ❑ Disorder to taste ❑ Disorder to smell
If there are any other symptoms you are experiencing psychologically, indicate below:	

Patient Signature: _____ **Date:** _____

Reviewed By: _____

INTELLIGENT HEALTH GROUP

Patients Name: _____

DIRECTION FORM

Patient Name: _____ Date of Birth: _____

Date of Loss: _____ Insurance Company: _____

Policy #: _____ Claim #: _____

I do hereby authorize Intelligent Health Group to act on my behalf and take all steps deemed reasonable and/or necessary for recovery and reimbursement from my law firm/insurer for any and all expenses arising on my behalf for medical rehabilitation provided by Intelligent Health Group as a result of injuries sustained in connection to the injury dated above. Such steps may include negotiation, mediation and/or arbitration proceedings.

I authorize the above-mentioned insurance company to make direct payments to Intelligent Health Group for all services provided to me.

I agree to fully cooperate with Intelligent Health Group in its efforts and will attend in person, if required to assist in the above efforts.

I agree to forward any and all payments that I may receive from my Extended Healthcare Insurance and/or Automobile Insurance Company to Intelligent Health Group pertaining to my treatments and products for this motor vehicle claim.

I also understand that if I or my legal representative/lawyer should settle my claim on a Full and Final basis with the insurance company it is my responsibility to include all outstanding amounts for treatment rendered at Intelligent Health Group. I understand that failure to do so could result in full financial responsibility for the payment of my account/outstanding to be paid by me.

I have inquired, understand, and agree to the fees being charged in relation to my treatment. A copy of this authorization shall be valid as original.

_____

Patient Name: _____ **Witness Name:** _____

Patient Signature: _____ **Witness Signature:** _____

Date: _____ **Date:** _____

INTELLIGENT HEALTH GROUP

Patients Name: _____

MEDICAL AUTHORIZATION FORM

Patient's Name: _____

Date of Birth: _____

Date of Loss: _____

Health Card No.: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Intelligent Health Group
57 Mill Street North, Unit 103
Brampton, ON L6X 1S9
FAX #: 647-493-2444
EMAIL: mill@intelligenthealthgroup.ca

I, the undersigned do hereby authorize you to release to Intelligent Health Group any and all information that may be requested pertaining to my physical and/or mental conditions, including, but not limited to:

- ❑ All records, reports and progress notes;
- ❑ All x-rays;
- ❑ All medical and/or legal opinions with respect to pertinent information regarding injuries sustained;
- ❑ Any other knowledge or information in your possession with respect to the foregoing;
- ❑ Obtaining extended healthcare, insurance and legal information;
- ❑ Need to communicate with health care provider (send correspondence/progress reports/discuss care)
- ❑ Other:

_____

I do not authorize Intelligent Health Group to release any medical or file information regarding me. Except to my treating health care provider, my insurer and my appointed representative and/or legal representative.

I acknowledge that a photocopy of this authorization shall be considered as effective as the original.

Patient Name: _____ **Witness Name:** _____

Patient Signature: _____ **Witness Signature:** _____

Date: _____ **Date:** _____

INTELLIGENT HEALTH GROUP

Patients Name: _____

FEE SCHEDULE

Initial Chiropractic Visit (includes treatment): $215
Subsequent visits: $112.81/hour

Initial Physiotherapy Visit (includes treatment): $215
Subsequent visits: $99.75/hour

Massage Therapy/Acupuncture 30 Minutes: $58.19

I, the undersigned, understand the above outlined fee schedule and acknowledge that my extended health carrier(s) will be charged in compliance with the above rates if I have extended healthcare coverage. These charges fall within the reasonable and customary fee guidelines for the province of Ontario. Whatever the extended healthcare company does not pay will be sent to my auto insurance company. If I do not have extended healthcare coverage the full cost will be sent to my auto insurance.

Patient Signature: _____ **Date:** _____

INTELLIGENT HEALTH GROUP

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:** _____