



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	<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		Relationship:	Phone:		
Family MD	Name:		Can we send your MD a progress report? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Phone and Fax:				
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	<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.
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	

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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If yes, complete below. If not, would you like us to arrange a consultation with a lawyer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Law Firm:		Telephone:	



Patients Name: _____

ACCIDENT PROFILE

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

Treatment Received from Medical Practitioner		
	Hospital	Family Physician
Date:		
Name/Location:		
Name of Doctor:		
Procedures/Examinations:	<input type="checkbox"/> X-ray <input type="checkbox"/> Exam <input type="checkbox"/> CT/MRI <input type="checkbox"/> Ultrasound	<input type="checkbox"/> X-ray <input type="checkbox"/> Exam <input type="checkbox"/> CT/MRI <input type="checkbox"/> Ultrasound Results:
Findings:		
Prescribed Medication:		

Previous Therapy Treatment			
Have you received treatment at any other therapy clinics for this accident?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Name of clinic:			
Start Date:		End Date:	
Type of therapy:	<ul style="list-style-type: none"> <input type="radio"/> Chiropractic <input type="radio"/> Physiotherapy <input type="radio"/> Massage Therapy <input type="radio"/> Acupuncture 	Frequency	

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

Patient Signature: _____

Date: _____

HEALTH HISTORY – 1 of 2

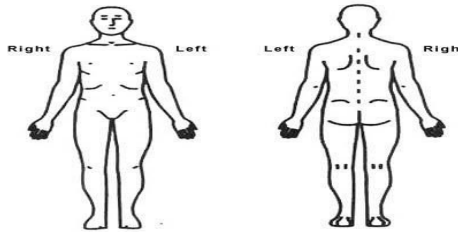
Personal Information							
Age:		Gender:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Height:		Weight:
						lbs	
Dominant Hand:		<input type="checkbox"/> Left	<input type="checkbox"/> Right	What side do you sleep on?			

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:	<input type="checkbox"/> F/T	<input type="checkbox"/> P/T	Missed time from work?	o Yes	<input type="checkbox"/> No	Returned to work?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Job Duties	<input type="checkbox"/> Sit	<input type="checkbox"/> Stand	<input type="checkbox"/> Walk	<input type="checkbox"/> Lift	<input type="checkbox"/> Carry	<input type="checkbox"/> Push	<input type="checkbox"/> Pull	<input type="checkbox"/> Bend
	<input type="checkbox"/> Grip	<input type="checkbox"/> Stoop	<input type="checkbox"/> Squat	<input type="checkbox"/> Kneel	<input type="checkbox"/> Reach			

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



Patients Name: _____

HEALTH HISTORY – 2 of 2

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)
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Medical History: Please complete 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"/> Heart disease	<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Obesity	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Anxiety disorders	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Digestive disorder
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Thyroid disorder
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Blood disorders	<input type="checkbox"/> Huntington's	<input type="checkbox"/> 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
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: _____

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	Partia l	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? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, how many?			Special needs: <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Dress/undress								
	Bathing								
	Feeding								
	Nail/Grooming								
	Homework assist								
	Supervision								
Additional Information:									

Patient Signature: _____ Date: _____



Patients Name: _____

NECK DISABILITY INDEX

<p>Section 1 – Pain Intensity</p> <ul style="list-style-type: none"> <input type="checkbox"/> I have no pain at the moment. <input type="checkbox"/> The pain is very mild at the moment. <input type="checkbox"/> The pain is moderate at the moment. <input type="checkbox"/> The pain is fairly severe at the moment. <input type="checkbox"/> The pain is very severe at the moment. <input type="checkbox"/> The pain is the worst imaginable at the moment. 	<p>Section 6 – Concentration</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can concentrate fully when I want to with no difficulty. <input type="checkbox"/> I can concentrate fully when I want to with slight difficulty. <input type="checkbox"/> I have a fair degree of difficulty in concentrating when I want to. <input type="checkbox"/> I have a lot of difficulty in concentrating when I want to. <input type="checkbox"/> I have a great deal of difficulty in concentrating when I want to. <input type="checkbox"/> I cannot concentrate at all.
<p>Section 2 – Personal Care (Washing, Dressing, etc.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can look after myself normally without causing extra pain. <input type="checkbox"/> I can look after myself normally but it causes extra pain. <input type="checkbox"/> It is painful to look after myself and I am slow and careful. <input type="checkbox"/> I need some help but manage most of my personal care. <input type="checkbox"/> I need help every day in most aspects of self-care. <input type="checkbox"/> I do not get dressed, I wash with difficulty and stay in bed. 	<p>Section 7 – Work</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can do as much work as I want to. <input type="checkbox"/> I can do my usual work, but no more. <input type="checkbox"/> I can do most of my usual work, but no more. <input type="checkbox"/> I cannot do my usual work. <input type="checkbox"/> I can hardly do any work at all. <input type="checkbox"/> I cannot do any work at all.
<p>Section 3 – Lifting</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can lift heavy weights without extra pain. <input type="checkbox"/> I can lift heavy weights but it gives extra pain. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. <input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. <input type="checkbox"/> I can lift very light weights. <input type="checkbox"/> I cannot lift or carry anything at all. 	<p>Section 8 – Driving</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can drive my car without any neck pain. <input type="checkbox"/> I can drive my car as long as I want with slight pain in my neck. <input type="checkbox"/> I can drive my car as long as I want with moderate pain in my neck. <input type="checkbox"/> I cannot drive my car as long as I want because of moderate pain in my neck. <input type="checkbox"/> I can hardly drive at all because of severe pain in my neck. <input type="checkbox"/> I cannot drive my car at all.
<p>Section 4 – Reading</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can read as much as I want to with no pain in my neck. <input type="checkbox"/> I can read as much as I want to with slight pain in my neck. <input type="checkbox"/> I can read as much as I want with moderate pain in my neck. <input type="checkbox"/> I cannot read as much as I want because of moderate pain in my neck. <input type="checkbox"/> I can hardly read at all because of severe pain in my neck. <input type="checkbox"/> I cannot read at all. 	<p>Section 9 – Sleeping</p> <ul style="list-style-type: none"> <input type="checkbox"/> I have no trouble sleeping. <input type="checkbox"/> My sleep is slightly disturbed (less than 1 hour sleepless). <input type="checkbox"/> My sleep is mildly disturbed (1-2 hours sleepless). <input type="checkbox"/> My sleep is moderately disturbed (2-3 hours sleepless). <input type="checkbox"/> My sleep is greatly disturbed (3-5 hours sleepless). <input type="checkbox"/> My sleep is completely disturbed (5-7 hours sleepless).
<p>Section 5 – Headaches</p> <ul style="list-style-type: none"> <input type="checkbox"/> I have no headaches at all. <input type="checkbox"/> I have slight headaches that come infrequently. <input type="checkbox"/> I have moderate headaches which come infrequently. <input type="checkbox"/> I have moderate headaches which come frequently. <input type="checkbox"/> I have severe headaches which come frequently. <input type="checkbox"/> I have headaches almost all the time. 	<p>Section 10 – Recreation</p> <ul style="list-style-type: none"> <input type="checkbox"/> I am able to engage in all my recreation activities with no neck pain at all. <input type="checkbox"/> I am able to engage in all my recreation activities, with some pain in my neck. <input type="checkbox"/> I am able to engage in most, but not all, of my usual recreation activities because of pain in my neck. <input type="checkbox"/> I am able to engage in a few of my usual recreation activities because of pain in my neck. <input type="checkbox"/> I can hardly do any recreation activities because of pain in my neck. <input type="checkbox"/> I cannot do any recreation activities at all.

Patient Signature: _____

Date: _____



Patients Name: _____

Reviewed By: _____

Score: _____

OSWESTRY DISABILITY INDEX

<p>Section 1 – Pain Intensity</p> <ul style="list-style-type: none"> <input type="checkbox"/> I have no pain at the moment. <input type="checkbox"/> The pain is very mild at the moment. <input type="checkbox"/> The pain is moderate at the moment. <input type="checkbox"/> The pain is fairly severe at the moment. <input type="checkbox"/> The pain is very severe at the moment. <input type="checkbox"/> The pain is the worst imaginable at the moment. 	<p>Section 7 – Sleeping</p> <ul style="list-style-type: none"> <input type="checkbox"/> My sleep is never disturbed by pain. <input type="checkbox"/> My sleep is occasionally disturbed by pain. <input type="checkbox"/> Because of pain, I have less than 6 hours sleep. <input type="checkbox"/> Because of pain, I have less than 4 hours sleep. <input type="checkbox"/> Because of pain, I have less than 2 hours sleep. <input type="checkbox"/> Pain prevents me from sleeping at all.
<p>Section 2 – Personal Care (washing, dressing, etc.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can look after myself normally without causing extra pain. <input type="checkbox"/> I can look after myself normally but it causes extra pain. <input type="checkbox"/> It is painful to look after myself and I am slow and careful. <input type="checkbox"/> I need some help but manage most of my personal care. <input type="checkbox"/> I need help every day in most aspects of my personal care. <input type="checkbox"/> I do not get dressed, I wash with difficulty and stay in bed. 	<p>Section 8 – Sex life (if applicable)</p> <ul style="list-style-type: none"> <input type="checkbox"/> My sex life is normal and causes no extra pain. <input type="checkbox"/> My sex life is normal but causes some extra pain. <input type="checkbox"/> My sex life is nearly normal but is very painful. <input type="checkbox"/> My sex life is severely restricted by pain. <input type="checkbox"/> My sex life is nearly absent because of pain. <input type="checkbox"/> Pain prevents any sex life at all.
<p>Section 3 - Lifting</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can lift heavy weights without extra pain. <input type="checkbox"/> I can lift heavy weights but it gives extra pain. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on a table). <input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. <input type="checkbox"/> I can lift only very light weights. <input type="checkbox"/> I cannot lift or carry anything at all. 	<p>Section 9 – Social Life</p> <ul style="list-style-type: none"> <input type="checkbox"/> My social life is normal and causes me no extra pain. <input type="checkbox"/> My social life is normal but increases the degree of pain. <input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests, i.e. sports. <input type="checkbox"/> Pain has restricted my social life and I do not go out as often. <input type="checkbox"/> Pain has restricted social life to my home. <input type="checkbox"/> I have no social life because of pain.
<p>Section 4 – Walking</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pain does not prevent me walking any distance. <input type="checkbox"/> Pain prevents me from walking more than 1mile. <input type="checkbox"/> Pain prevents me walking more than ¼ of a mile. <input type="checkbox"/> Pain prevents me walking more than 100 yards. <input type="checkbox"/> I can only walk using a stick or crutches. <input type="checkbox"/> I am in bed most of the time and have to crawl to the toilet. 	<p>Section 10 – Traveling</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can travel anywhere without pain. <input type="checkbox"/> I can travel anywhere but it gives extra pain. <input type="checkbox"/> Pain is bad but I manage journeys of over two hours. <input type="checkbox"/> Pain restricts me to short necessary journeys under 30 minutes. <input type="checkbox"/> Pain prevents me from traveling except to receive treatment.
<p>Section 5 – Sitting</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can sit in any chair as long as I like. <input type="checkbox"/> I can sit in my favorite chair as long as I like. <input type="checkbox"/> Pain prevents me from sitting for more than 1 hour. <input type="checkbox"/> Pain prevents me from sitting for more than ½ hour. <input type="checkbox"/> Pain prevents me from sitting for more than 10 minutes. <input type="checkbox"/> Pain prevents me from sitting at all. 	<p>Section 11 - Previous Treatment</p> <p>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.</p> <ul style="list-style-type: none"> <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, please state the type of treatment you have received)
<p>Section 6 – Standing</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can stand as long as I want without extra pain. <input type="checkbox"/> I can stand as long as I want but it gives me extra pain. <input type="checkbox"/> Pain prevents me from standing for more than 1 hour. <input type="checkbox"/> Pain prevents me from standing for more than ½ an hour. <input type="checkbox"/> Pain prevents me from standing for more than 10 minutes. <input type="checkbox"/> Pain prevents me from standing at all. 	

Patient Signature: _____

Date: _____

Reviewed By: _____

Score: _____



Patients Name: _____

PSYCHOLOGICAL SYMPTOMS CHECKLIST

Check all that apply since the motor vehicle accident

Psychological 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

Neurocognitive Symptoms

- 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: _____



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:** _____



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: _____



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: _____



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: _____