INTELLIGENT HEALTH GROUP

Patients Name: _____

WSIB 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 for appointment confirmations, reminders, updates, monthly health newsletters and general correspondence?					

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	

WSIB Information					
Consultant's Name		Telephone:		Fax:	
Date of Accident:		Claim #:			
Where was injured?					

Work Information			
Employer:		Occupation:	
Telephone:		Fax:	
Address:			
Did you take time off work:		Date last worked:	

INTELLIGENT HEALTH GROUP

Patients Name: _____

ACCIDENT PROFILE

Accident Details
How did the accident happen? (Put as much detail as possible)

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:	○ Chiropractic ○ Physiotherapy ○ Massage Therapy ○ Acupuncture	Frequency	

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

Patient Signature: _____ **Date:** _____

57 Mill Street North, Unit 103, Brampton, ON L6X 1S9

INTELLIGENT HEALTH GROUP

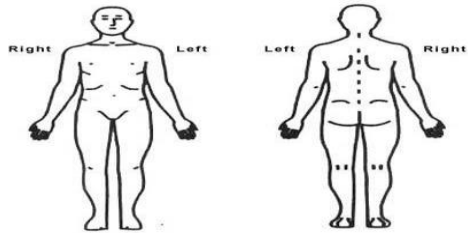
Patients Name: _____

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?	○ 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)
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:** _____

57 Mill Street North, Unit 103, Brampton, ON L6X 1S9

INTELLIGENT HEALTH GROUP

Patients Name: _____

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)

INTELLIGENT HEALTH GROUP

Patients Name: _____

- ❑ Naturopath
- ❑ Iridologist
- ❑ Psychotherapist

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:** _____

FUNCTIONAL HEALTH ASSESSMENT

Patient Name:_____ Date: _____

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**