Central Health Care
FEEL BETTER, MOVE BETTER, BE BETTER

Confidential Patient Intake Form

The information requested below must be completed accurately and in full to assist us in treating you safely.

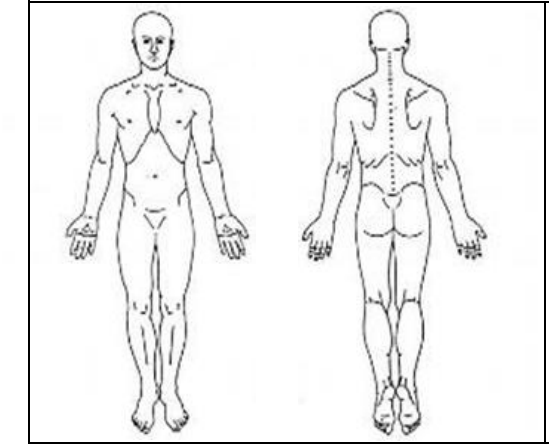
Verified:

Name:		Today's Date (D/M/Y):
Address:	City:	Postal Code:
Home Ph.	Cell Ph.	Email:
Date of Birth (D/M/Y):	Age:	☐ Male ☐ Female
Occupation:	Employer:	
Medical Doctor:	Health Card #:	Expiry Date:
☐ Work related injury/ accident (WSIB) ☐ Motor vehicle accident (MVA) Date of accident:		
Previous Therapy? ☐ Acupuncture ☐ Chiropractic ☐ Physiotherapy ☐ Massage Therapy Last Visit? Practitioner/ Clinic Name:		

Current Complaint

Reason for Visit/ Current Complaint(s)?

What do you believe caused this?	When did it occur?
Associated Symptoms?	



Mark area(s) of pain or unusual feeling on diagram.

- • • Numbness
- X X Burning
- O O Tingling
- V V Sharp & Stabbing
- / / Aching & Tension

What makes it better?

What makes it worse?

Frequency of Pain: ☐ Infrequent <25% ☐ Occasional 25-50% ☐ Frequent 50-75% ☐ Constant >75%

On average, how intense has your pain been **over the past week**? Click one.

No pain 0 1 2 3 4 5 6 7 8 9 10 **Worst pain possible**

Severity ☐ Mild ☐ Mild to Moderate ☐ Moderate ☐ Moderate to Severe ☐ Severe

806 Gordon St. Guelph ON N1G1Y7

Medical History

Disease

- ☐ AIDS/ HIV
- ☐ Allergies: _____
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Drink Alcohol # Drinks / week ___
- ☐ Epilepsy
- ☐ Fainting
- ☐ Headache
- ☐ Hearing Loss
- ☐ Hepatitis A B C D
- ☐ Insomnia
- ☐ Mental/ Emotional Difficulty
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Sinus Trouble
- ☐ Thyroid Condition
- ☐ Tinnitus
- ☐ Tuberculosis TB
- ☐ Vertigo/ Dizziness
- ☐ Vision Loss

Cardiovascular & Lung

- ☐ Anemia
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ High Cholesterol
- ☐ Heart Disease
- ☐ Heart Attack/ MI
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Lung/ Breathing Issue
- ☐ Mechanical Heart Valve
- ☐ Pacemaker
- ☐ Shortness of Breath
- ☐ Smoker # Cigarettes / day ___
- ☐ Stroke/ TIA
- ☐ Varicose veins

Skin

- ☐ Bruise easily
- ☐ Eczema/ Psoriasis
- ☐ Rash
- ☐ Skin Infection
- ☐ Other Skin Condition

Gastrointestinal

- ☐ Abrupt Weight Loss
- ☐ Abrupt Weight Gain
- ☐ Colitis
- ☐ Diverticulitis
- ☐ GERD/ GORD
- ☐ Hepatitis
- ☐ Irritable Bowel
- ☐ Ulcer

Genitourinary

- ☐ Kidney Disease
- ☐ Prostate Disease
- ☐ Sexual Dysfunction
- ☐ STD's
- ☐ Pregnant - Due Date: _____
- ☐ Exercise Hours per week? ___
  - ☐ Light
  - ☐ Moderate
  - ☐ Strenuous

Musculoskeletal

- ☐ Artificial Joint/ Pins/ Screws
- ☐ Bone Fracture
- ☐ Connective Tissue Disorder
- ☐ Dislocated Joint
- ☐ Fibromyalgia
- ☐ General Stiffness
- ☐ Weakness
- ☐ Numbness/ Tingling
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Parkinson's
- ☐ Rheumatoid Arthritis
- ☐ Peripheral Neuropathy
- ☐ Multiple Sclerosis
- ☐ Scoliosis
- ☐ Spinal Disc Disease
- ☐ Other Medical Conditions Not Listed:

_____

_____

_____

Please note any significant **family history** of the above listed conditions:

Have you **ever** had any major **surgeries or operations**? ☐ Yes ☐ No
If yes, please describe what and when:

Have you had any **imaging (x-ray, US, CT, MRI)** within the last year? ☐ Yes ☐ No

Medications

Please list **all** prescription & non-prescription **medications** you are currently taking and the **reason** for them:

How did you hear about our office or who referred you?

☐ Google ☐ Sunlife/Lumino ☐ Yellowpages

☐ Patient / Family / Friend _____

☐ Health Professional _____

☐ Other _____

Office Policies

FEES

It is the policy of this clinic that payment is required at the time that services are rendered.

No credit or accumulation of fees is permitted.

Cash, Cheque or Debit is accepted. All NSF cheques will be charged a $30 fee.

MISSED APPOINTMENTS & ASSOCIATED FEE

Reminder calls/emails are a courtesy provided by the clinic. However, remembering your appointment is your responsibility.

If you are unable to keep an appointment, 24 hours cancellation notice is required.

Without 24 hours prior notification, you will be billed a cancellation fee.

EXTENDED HEALTH CARE COVERAGE

Many extended health care insurance plans cover therapy. Check with your employer for details.

Fees recovered from extended health insurance plans are the patient's responsibility.

If other financial arrangements are required, please discuss them with your individual therapist prior to your treatment.

I clearly understand and agree that ALL services rendered to me are charged directly to me and that I am personally responsible for payment.

I have read and acknowledged all of the above information.

I have completed honestly, accurately and in full this patient intake form and understand the importance of informing my doctor/therapist of any changes.

Patient Signature: _____ Date: _____