INTELLIGENT HEALTH GROUP

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**	☐ Single ☐ Divorced	☐ Married ☐ Separated	☐ Common Law ☐ Widowed
Emergency Contact name		Relationship:		Phone:	
Family MD	Name:	Can we send your MD a progress report? ☐ Yes ☐ No			
	Phone:				

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 ◯

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	

HEALTH HISTORY

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 ☐ Aneurysm	☐ Heart Attack ☐ Heart Disease/Pacemaker ☐ High Cholesterol ☐ High Blood Pressure ☐ Stroke/TIA/Aneurysm ☐ Blood Clots ☐ Angina ☐ Epilepsy	☐ Respiratory Disease ☐ Asthma/Chronic Bronchitis ☐ Thyroid disease/problems ☐ Kidney disease/problems ☐ Liver disease/problems ☐ Skin problems ☐ Psychological disorder ☐ Fibromyalgia/Chronic Fatigue

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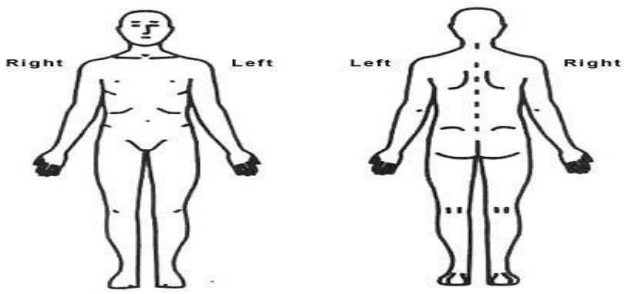
Where is your pain? ***Use the diagram to indicate your problem areas***		**On a scale of 0 to 10, with 0 being no pain and 10 being excruciating pain, what level is your pain?** **0 1 2 3 4 5 6 7 8 9 10** ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

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	☐ Arthritis	☐ Stroke	☐ Other:
☐ Obesity	☐ Heart disease	☐ Depression	
☐ Diabetes	☐ High blood pressure	☐ Anxiety disorders	
☐ Osteoporosis	☐ High cholesterol	☐ 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	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**

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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)
- ☐ 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:** _____

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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:** _____