activehealth CENTRE

New Patient
Information Form

Please tell us about yourself (Please print)

Name: _____

Address: _____ **City:** _____ **Postal Code:** _____

Date of Birth: D ____**M**____**Y**____ **Age:** ____ **Gender: M F**

Marital Status: (please circle) Married Single Divorced Widowed

Social Insurance Number (If WSIB): _____

Health Card No: _____

Email: _____

Home Phone: _____ **Leave Message: Yes No**

Work Phone: _____ **Leave Message: Yes No**

Mobile Phone: _____ **Leave Message: Yes No**

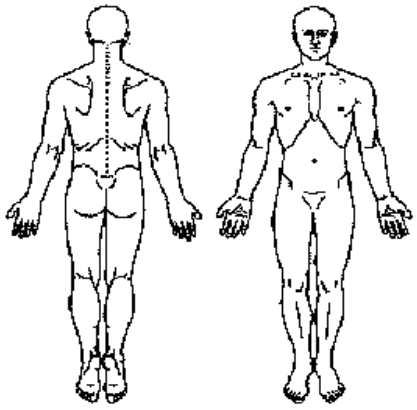
What is your Occupation? _____

Duties: _____

Emergency Contact: _____ **Phone:** _____

Referred by: _____ **e.g. patient/sign/ad/etc.**

Please tell us about the reason for your visit



1. **What is your main health complaint?**
   _____
2. **When did your symptoms first begin?**
   _____
3. **Do you feel your problem is:** (please circle)
   a) temporary b) permanent c) unsure
4. **On the body diagram to the right, please indicate the problem area(s) using (P) pain, (N) numbness, and (W) weakness.**
5. **10 being the worst pain you have ever experienced what would you rate your pain?**
6. **Do you have any additional/secondary areas of complaint? Please describe.**

_____
_____
_____
_____

Please turnover and continue on the next page →

7. What activities are you having problems with? (Please circle)

1) Balance	5) Housework	9) Pushing	13) Standing
2) Bending	6) Kneeling	10) Reaching	14) Stooping
3) Fatigue	7) Lifting	11) Sitting	15) Traveling
4) Gripping	8) Pulling	12) Sleeping	16)Walking

Other_____

8. Do you smoke? Yes/No For how long? _____ How many per day? _____

9. Which of the following provides some comfort? (Please circle)

1) Rest	5) Ice
2) Lying down	6) Medication
3) Changing position	7) Stretching
4) Heating pad	8) Other _____

10. Which of the following have you experienced?

Please indicate as follows: (P) past (O) occasionally (F) frequently

General muscle aches	[ ]	Eyes, ears, nose, throat	[ ]
Seizures	[ ]	Lung problems/asthma	[ ]
Fainting	[ ]	Bladder, kidney, bowel	[ ]
Neurological disease	[ ]	Hernia	[ ]
Mental disorders	[ ]	Digestive problems	[ ]
Memory problems	[ ]	HIV/AIDS, Hep C exposure	[ ]
Faulty posture	[ ]	Foot trouble	[ ]
Other _____	[ ]		

Females only:

Menstrual Pain [ ] PMS [ ]

Are you pregnant? Yes No

Do you take the Birth Control Pill? Yes No

11. Please check if <u>YOU</u> or anyone in <u>your family</u> now have or have had any of the following:

(If so, indicate relationship)

Arthritis	[ ]	_____	High blood pressure	[ ]	_____
Cancer	[ ]	_____	Obesity	[ ]	_____
Diabetes	[ ]	_____	Osteoporosis	[ ]	_____
Heart Disease	[ ]	_____	Stroke	[ ]	_____

12. Please list any allergies: _____

Please turnover and continue on the next page →

13. Please list any serious accidents, falls, fractures, hospitalizations and surgeries (type and year):

_____

_____

_____

14. Please list any medications previous and present:

_____

For Acupuncture Patients only (Please print)

Do you have any bleeding or clotting disorders? _____

Are you currently pregnant or trying to become pregnant? _____

Are you on blood thinners or medication with a similar result? _____

Long-term goals of acupuncture treatment (to be filled out by acupuncturist):

Previous health care (Please print)

Previous chiropractor's name: _____ Phone: _____

Date of last chiropractic visit: _____

Medical doctor's name: _____ Phone: _____

Billing information (Please print)

General

Do you have Extended Health Coverage: Yes No Unsure

Name of Extended Health Provider:

_____

What services are covered?

- ❑ **Chiropractic**
- ❑ **Physiotherapy**
- ❑ **Massage Therapy**
- ❑ **Acupuncture**
- ❑ **Foot Orthotics**
- ❑ **Naturopathy**
- ❑ **Other** _____

Type of injury

Is this a Workplace Safety & Insurance Board injury? Yes No

Are your injuries related to a Motor Vehicle Accident? Yes No

Please turnover and continue on the next page →

Our fee schedule

The account is the responsibility of the patient. Payment is expected in full when service is rendered.

- **Initial Visit $80.00**
- **Subsequent Visit $50.00**
- **Acupuncture $50.00**
- **Extended Visit $50.00**
- **Concussion Visit $60.00**
- **Active Release Technique $50.00**
- **Physiotherapy Initial Visit $90.00**
- **Physiotherapy Subsequent $70.00**
- **X-rays Varies**
- **Costs associated with specific procedures or treatments will be discussed as required.**

We understand that there will be circumstances for which you may not be able to keep your appointment, please call ahead to cancel and re-schedule the appointment. Missed appointments will be charged a $15.00 fee.

Consent

- ❑ **Fee Structure: I have read the above, and agree and understand that I am responsible for all charges relating to my visit.**
- ❑ **Personal Information Release: I consent to release personal information solely to Active Health Centre, and I understand that all such information will be held in strict confidence and only released with my written consent and/or as required by governing law.**
- ❑ **Exam Consent: I consent to an examination in this office.**
- ❑ **Record Transfer Authorization: I consent to the release of a medical report to my family doctor.**
- ❑ **Understanding: I have had the opportunity to ask questions related to the content of this form.**

Date: _____/_____/_____

_____ _____

Signature of patient, parent or guardian **Witness Signature**

_____ _____

Printed name of patient, parent or guardian **Printed Name of Witness**

(Parent/guardian must sign if patient is under 18 years of age)

Thank you