FULL MOTION Health & pain management

Phone: (403) 282-5590
Fax: (403)282-3877

#1766, 1632 – 14th Avenue NW
Calgary, Alberta T2N 1M7

Patient Intake Form

Name: ______________________ Date: ______________

Address: ______________________________________

City, Province: ______________________ Postal Code: ______________

Phone Number: (H) ______________ (W) ______________ (C) ______________

Alberta Health Care # ______________ Date of Birth (mm/dd/yyyy) ______________

Email: ______________________ Gender: ( ) Female ( ) Male

We use email for receipts, reminders and newsletters; I do not want to receive e-mails ☐

Occupation: ______________________

Extended Health Insurance Company: ______________ Policy/ ID # ______________

Insured Member / Spouse / Child: ______________ Group /Ref #______________

Emergency Contact

Name: ______________________

Phone Number: (H) ______________ (W) ______________

Medical Doctor

Name: ______________________ Phone Number: ______________

Address: ______________________________________

Date of last physical: ______________

Who may we thank for the referral? ☐ **Full Motion Website** ☐ **Yellow Pages (Book / Internet)** ☐ **Direct-bill Website**

☐ **Mall / Walk In** ☐ **Family / Friend Name** ______________ ______________ ☐**Other** ______________

What goal do you hope to attain with care?

- Pain relief __________
- Correction of problem __________
- Preventative care __________

Is this injury the result of a motor vehicle accident: Yes No If yes, please ensure the treating doctor is informed to ensure the appropriate paper work is completed.

Is this injury the result of a work related accident: Yes No If yes, has WCB been notified: Yes No

What services are you interested in? Please select all that apply

☐ Chiropractic Treatment	☐ Active Release Therapy	☐ Custom Orthotic Therapy
☐ Low Level Laser Therapy	☐ Massage Therapy	☐ F.A.K.T.R.
☐ Nutritional Supplements	☐ Graston Technique	☐ Acupuncture

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General Health History

Musculoskeletal System

_____ Low back problems
_____ Pain between shoulders
_____ Neck problems
_____ Arm problems
_____ Leg problems
_____ Swollen joints
_____ Painful joints
_____ Stiff joints
_____ Sore muscles
_____ Walking problems
_____ Weak muscles
_____ Broken bones
_____ Arthritis
_____ Foot problems
_____ Tail bone pain

Nervous System

_____ Pain
_____ Numbness
_____ Tingling
_____ Dizziness
_____ Fainting
_____ Headaches
_____ Seizures
_____ Forgetfulness
_____ Confusion
_____ Nervousness
_____ Tremors
_____ Imbalance
_____ Sciatica

Genito-urinary System

_____ Bladder problems
_____ Frequent urination
_____ Excessive urination
_____ Scanty urination
_____ Urgent urination
_____ Painful urination
_____ Discolored urine
_____ Blood in urine
_____ Loss of control
_____ Kidney infection
_____ Prostate problems
_____ Nocturia
_____ Sexual dysfunction

Cardio-vascular / Pulmonary System

_____ Chest pain
_____ Difficulty breathing
_____ Persistent cough
_____ Coughing phlegm / blood
_____ Rapid heart beat
_____ High blood pressure
_____ Heart problems
_____ Lung problems
_____ Varicose veins
_____ Poor circulation
_____ Atherosclerosis
_____ Previous stroke
_____ Asthma
_____ Wheezing

Gastro-intestinal System

_____ Poor appetite
_____ Excessive hunger
_____ Difficulty chewing
_____ Difficulty swallowing
_____ Excessive thirst
_____ Nausea
_____ Vomiting food
_____ Vomiting blood
_____ Diarrhea
_____ Constipation
_____ Black stool
_____ Hemorrhoids
_____ Liver problems
_____ Excessive gas
_____ Heartburn
_____ Gall bladder trouble
_____ Weight loss/gain
_____ Colitis
_____ Colon problems
_____ Problems digesting
_____ Abdominal pain
_____ Jaundice
_____ Bloating

Women Only

_____ Cramps
_____ Heavy / light flow
_____ Irregular cycle
_____ Painful cycle
_____ Vaginal discharge
_____ Vaginal pain
_____ Sore breasts
_____ Lumps in breasts
Are you pregnant?
Yes No
Due date ____________

Eyes, Ears, Nose Throat

_____ Eye strain
_____ Eye pain
_____ Eye inflammation
_____ Ear noises
_____ Ear discharge
_____ Hearing loss
_____ Ear pressure
_____ Jaw pain
_____ Dental problems
_____ Hoarseness
_____ Difficult speech
_____ Frequent colds
_____ Sinus problems
_____ Enlarged glands
_____ Enlarged thyroid
_____ Nose bleeds

General Health

_____ Allergies
_____ Chills
_____ Fevers
_____ Sweats
_____ Significant weight change
_____ Depression
_____ Anxiety
_____ Recent infections

Habits and Lifestyle Name: ______________________________

Do you smoke?	Yes	No	# of packs per day ________			
Do you consume alcohol?	Yes	No	Number of drinks per week _________			
Do you exercise?	Yes	No	Number of times per week __________			
Rate your stress level	Low	Medium	High			
Rate your appetite	Poor	Fair	Good	Excellent		
Rate your diet	Poor	Fair	Good	Excellent		
How many meals per day	1	2	3	4	5	6+

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Pain Drawing

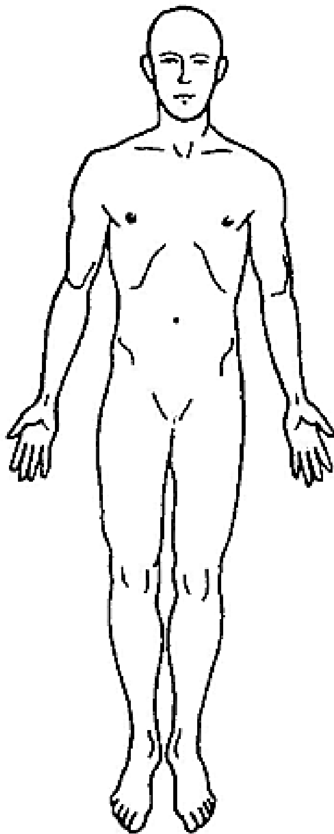
Name: ___________________________ Today's Date: ___________________________

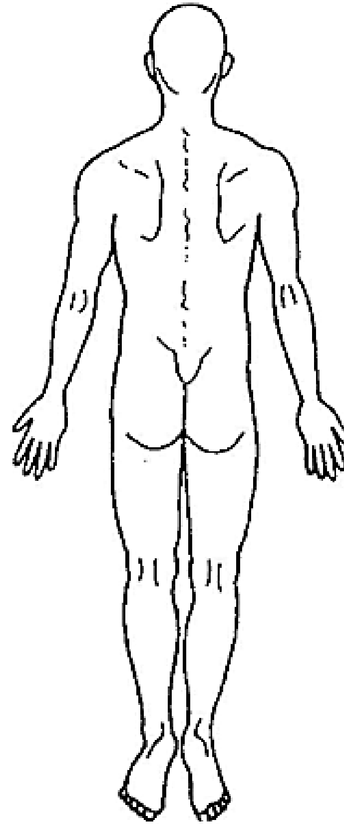
TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate symbol(s) listed below.

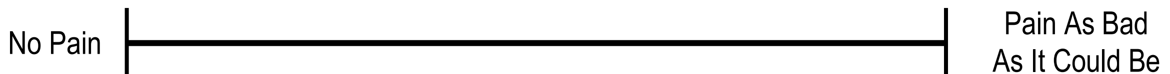
Ache >>>> >>>>	Numbness ==== ====	Pins and Needles oooo oooo
Burning xxxx xxxx	Stabbing //// ////	Throbbing ----





Visual Analogue Pain Scale

How much pain have you had because of your condition in the past week?
Please mark on the line to indicate how severe your pain has been.

No Pain  Pain As Bad As It Could Be

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Financial Policy

1. Payment in CASH, DEBIT, VISA OR MASTERCARD is required at the time service is rendered, unless other arrangements have been made in advance.

2. Many private insurance companies provide full or partial coverage of chiropractic claims. These additional policies are between you and your insurance company. You can be assured that we will help fill out your claim accurately and as quickly as possible to assure you maximum benefits. We ask, however that you keep your account with us up to date.

Students (full-time, under 25) / seniors (65 years and older) reduced rates apply for certain services. Please inquire.

For further information on fees and rates for additional services provided by the chiropractic office please speak with the chiropractor or administrative assistant, they will be happy to answer all your billing questions.

PLEASE READ AND SIGN BELOW
I understand and agree that I am responsible for payment at the time of service unless previous arrangements have been made with the clinic. I also understand and agree that my private health insurance will be directly billed (if registered with Clinic) for services and that I have to send in my claims for reimbursement if direct billing is not possible, unless I am involved in a motor vehicle accident or workers' compensation claim.

Name: ________________________________ **Signature:** ___________________________________

CANCELLATION POLICY
Please note that the clinic cancellation policy requires 24 hours notice for all cancellations**. This is to ensure that patients who require care can be accommodated as quickly as possible. Your care is important to us, extraneous circumstances are understandable and will be accommodated accordingly; otherwise please call our office in advance to reschedule your appointment. Please note**, all missed appointments with less than 24 hours notice will be charged cancellation fee **regardless of any other reduced rates. This is payable by the patient and is not reimbursable by insurance.**

Name: ________________________________ **Signature:** ___________________________________

Reminder Calls or E-mails Via:_________________________________