PEAKCHIRO
MASSAGE + ACUPUNCTURE + PHYSIO

## Patient Intake Form

Name: _____ Date: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Home Tel: _____ Cell No.: _____
Email: _____
**would you like to be reminded of appointments via email? Yes No**

Date of Birth (DD/MMM/YYYY): _____

Occupation: _____ Employer: _____
Business Telephone No.: _____
Address: _____
City: _____ Province: _____ Postal Code: _____

Spouses Name: _____ Children: _____
Closest relative: _____ Contact No.: _____

Extended Health Care Company: _____
Policy Number: _____ Certificate Number: _____
Policy Holder: _____ Policy Holder DOB (D/M/Y) _____

**How did you hear about the office?:** ☐ Friend ☐ Google ☐Sign Other:_____

**Claim will be made again:**
1. Recent Motor Vehicle Accident (MVA) ☐ **YES** ☐ **NO** (if yes, see attached)
2. Work related injury/accident (WSIB) ☐**YES** ☐**NO** (if yes, see attached)

**Prior Chiropractic / Physiotherapy / Massage Care:**
Name(s): _____ Tel. No.: _____
X-rays taken: ☐**YES** ☐**NO** Date:
Results: ☐**Excellent** ☐**Good** ☐**Fair** ☐**Poor**
Date of last Visit: _____

**Your Medical Doctor:**
Name: _____
Tel. No.: _____ Fax No.:_____
Address: _____ City: _____
Date of last appointment: _____ Date of last physical: _____
May we contact your medical Doctor? ☐ **YES** ☐**NO** **Signature:**_____

# Patient Intake Form

## Habits of Lifestyle

Do you smoke?: ☐ Yes ☐ No

Do you consume alcohol?: ☐ Yes ☐ No

Do you exercise?: ☐ Yes ☐ No

Exercise activities: _____

_____

Rate your sleep:

Average Hours per night: ☐4 - 6 ☐6 - 8 ☐8 - 10 ☐12+

Do you wake rested? ☐ Yes ☐ No

Rate your appetite: ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent

Rate your diet: ☐ Poor ☐ Fair ☐ Medium ☐ Good ☐ Excellent

Do you eat regularly: ☐ Breakfast ☐ Lunch ☐ Dinner

Do you eat per day: ☐ 1 meal ☐ 2 meals ☐3 meals ☐4 meals ☐More than 4 Meals

When did you last see your Dentist / Hygienist?: _____

Have you had any Surgeries / Operations?: ☐ Yes ☐ No

If yes, list: _____

_____

Surgery recommended but not performed list: _____

Do you take vitamins: ☐ Yes ☐ No Which ones: _____

Have you ever been knocked unconscious: ☐ Yes ☐No If yes, for how long: _____

List any medications or drugs you are currently taking: _____

Any Major Falls / Accidents? Please list: _____

Have you previously been hospitalized: ☐ Yes ☐ No

Please list: _____

Any family health conditions or problems: ☐ Yes ☐ No

Please list: _____

_____

_____

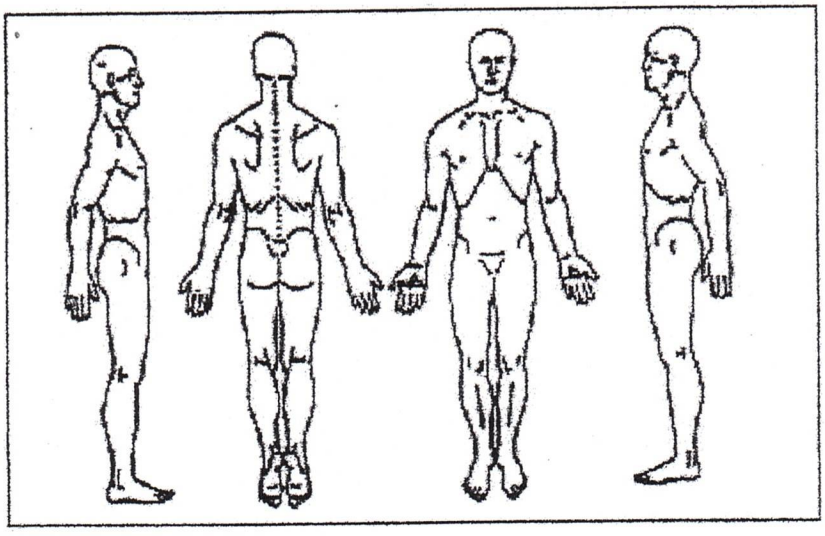
Reason for consulting the office: _____

_____

Expectations: _____

## Patient Intake Form

- Please identify on the diagram where you feel the described symptoms.
- Use the appropriate symbols (see below).
- Mark any areas of radiation.
- Include all affected areas.



| | |
|---|---|
| Numbness | ● |
| Pins & Needles | ◇ |
| Burning | × |
| Aching | * |
| Stabbing | ○ |

**Have you ever had any of the following?**
**Please check.**

| | | | |
|---|---|---|---|
| ☐ Aneurysm | ☐ Heart Conditions | ☐ Osteoporosis | ☐ Arthritis |
| ☐ Psoriases | ☐ Sleeping difficulty | ☐ Diabetes | ☐ Allergies |
| ☐ Epilepsy | ☐ Cancer | ☐ Strokes | ☐ Hepatitis |
| ☐ 'Nerves' | ☐ Fatigue | ☐ Polio | ☐ V.D. |
| ☐ HIV | ☐ Sinus Conditions | ☐ pneumonia | ☐ Asthma |
| ☐ Pleurisy | ☐ Respiratory conditions | ☐ Ankle swelling | ☐ Varicose veins |
| ☐ Foot pain | | | |

**Have you had any of the following Childhood Condition?**
**Please check.**

| | | | |
|---|---|---|---|
| ☐ Measles | ☐ Mumps | ☐ Chicken pox | ☐ Whooping cough |
| ☐ Ear infections | ☐ Scarlet fever | ☐ Chronic ill | ☐ Diphtheria |
| ☐ Rheumatic fever | ☐ Typhoid fever | ☐ Tubes in ears | |

Name: _____ Date: _____

Please check the appropriate box for any of the following symptoms which you now have or have had before.

**C = Constant F = Frequently O = Occasional**

**Neurological**

C F O
- ☐ ☐ ☐ chills
- ☐ ☐ ☐ allergy
- ☐ ☐ ☐ convulsions
- ☐ ☐ ☐ dizziness
- ☐ ☐ ☐ fainting
- ☐ ☐ ☐ fevers
- ☐ ☐ ☐ headaches
- ☐ ☐ ☐ loss of sleep
- ☐ ☐ ☐ nervousness
- ☐ ☐ ☐ depression
- ☐ ☐ ☐ neuralgia
- ☐ ☐ ☐ numbness
- ☐ ☐ ☐ sweats
- ☐ ☐ ☐ loss of weight
- ☐ ☐ ☐ tremors

**Muscle & Joint**

C F O
- ☐ ☐ ☐ arthritis
- ☐ ☐ ☐ bursitis
- ☐ ☐ ☐ foot trouble
- ☐ ☐ ☐ hernia
- ☐ ☐ ☐ low back pain
- ☐ ☐ ☐ neck pain
- ☐ ☐ ☐ neck stiffness
- ☐ ☐ ☐ pain between shoulders

**Cardio-Vascular**

C F O
- ☐ ☐ ☐ rapid heartbeats
- ☐ ☐ ☐ slow heartbeat
- ☐ ☐ ☐ swelling of ankles
- ☐ ☐ ☐ hardening of arteries
- ☐ ☐ ☐ high blood pressure
- ☐ ☐ ☐ low blood pressure
- ☐ ☐ ☐ pain over heart
- ☐ ☐ ☐ poor circulation

**Respiratory**

C F O
- ☐ ☐ ☐ sinus infection
- ☐ ☐ ☐ enlarged glands
- ☐ ☐ ☐ enlarged thyroid
- ☐ ☐ ☐ sore throat
- ☐ ☐ ☐ tonsillitis
- ☐ ☐ ☐ eye pains
- ☐ ☐ ☐ failing vision
- ☐ ☐ ☐ far sighted
- ☐ ☐ ☐ gum trouble
- ☐ ☐ ☐ hay fever
- ☐ ☐ ☐ hoarseness
- ☐ ☐ ☐ nasal obstruction
- ☐ ☐ ☐ near sighted
- ☐ ☐ ☐ nosebleeds
- ☐ ☐ ☐ chest pain
- ☐ ☐ ☐ chronic cough
- ☐ ☐ ☐ difficulty breathing
- ☐ ☐ ☐ spitting blood
- ☐ ☐ ☐ throat phlegm
- ☐ ☐ ☐ wheezing

**Eyes. Ears, Nose& Throat**

C F O
- ☐ ☐ ☐ colds
- ☐ ☐ ☐ cross eyed
- ☐ ☐ ☐ deafness
- ☐ ☐ ☐ asthma
- ☐ ☐ ☐ ear aches
- ☐ ☐ ☐ ear discharge
- ☐ ☐ ☐ ear noises

**Skin**

C F O
- ☐ ☐ ☐ boils
- ☐ ☐ ☐ bruises easily
- ☐ ☐ ☐ dryness
- ☐ ☐ ☐ hives or allergy
- ☐ ☐ ☐ itching
- ☐ ☐ ☐ skin rash
- ☐ ☐ ☐ varicose veins

**Genito-Urinary**

C F O
- ☐ ☐ ☐ bed wetting
- ☐ ☐ ☐ blood in urine
- ☐ ☐ ☐ frequent urination
- ☐ ☐ ☐ lose control of urine
- ☐ ☐ ☐ Kidney infection
- ☐ ☐ ☐ painful urination
- ☐ ☐ ☐ prostate trouble
- ☐ ☐ ☐ pus in urine
- ☐ ☐ ☐ smell of urine

**Pain or Numbness:**

C F O
- ☐ ☐ ☐ shoulders
- ☐ ☐ ☐ arms
- ☐ ☐ ☐ hands
- ☐ ☐ ☐ hips
- ☐ ☐ ☐ legs
- ☐ ☐ ☐ Knees
- ☐ ☐ ☐ ankles
- ☐ ☐ ☐ swollen joints
- ☐ ☐ ☐ painful tailbone
- ☐ ☐ ☐ sciatica
- ☐ ☐ ☐ heels of feet
- ☐ ☐ ☐ arches of feet
- ☐ ☐ ☐ top of feet

**Gastro-Intestinal**

C F O
- ☐ ☐ ☐ Excessive hunger
- ☐ ☐ ☐ burping/gas
- ☐ ☐ ☐ liver trouble
- ☐ ☐ ☐ colitis
- ☐ ☐ ☐ colon trouble
- ☐ ☐ ☐ constipation
- ☐ ☐ ☐ diarrhea
- ☐ ☐ ☐ difficult digestion
- ☐ ☐ ☐ distension of abdomen
- ☐ ☐ ☐ stomach pain
- ☐ ☐ ☐ gall bladder problem
- ☐ ☐ ☐ hemorrhoids
- ☐ ☐ ☐ jaundice
- ☐ ☐ ☐ poor appetite
- ☐ ☐ ☐ nausea
- ☐ ☐ ☐ vomiting
- ☐ ☐ ☐ vomit blood

**For Women Only**

C F O
- ☐ ☐ ☐ cramps
- ☐ ☐ ☐ heavy flow
- ☐ ☐ ☐ light flow
- ☐ ☐ ☐ irregular cycle
- ☐ ☐ ☐ painful cycle
- ☐ ☐ ☐ discharge
- ☐ ☐ ☐ sore breasts

Menopausal ☐ Yes ☐ No

Last Cycle: _____

Pregnant: ☐ Yes ☐ No

Due date: _____

# CANADIAN CHIROPRACTIC PROTECTIVE ASSOCIATION

## Informed Consent to Chiropractic Treatment FORM L

There are risks and possible risks associated with manual therapy techniques used by doctors of chiropractic. In particular you should note:

a) While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

b) There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke. Recent studies suggest that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in progress. However, you are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with upper cervical adjustment is extremely remote;

c) There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

d) There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some doctors of chiropractic.

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this Consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including any recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

**Dated this_____ day of_____, 20_____.**

**Patient Signature (Legal Guardian)** **Witness of Signature**

**Name:_____** **Name:_____**
**(please print)** **(please print)**

CCPA12.08 (ENGLISH)

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## INFORMED CONSENT FOR PHYSIOTHERAPY TREATMENT

As part of the physiotherapy treatments, certain procedures and devices may be utilized as the use of heat, ice, electrotherapy, ultrasound, light therapy and manual therapy.

As part of the exercise program certain procedures, devices and equipment may be utilized such as weight machines, exercise cardiovascular work and functional tasks.

I understand and I am informed that:

1. There are some slight risks to treatments and assessment, including, but not limited to muscle strains, sprains, disc injuries and burns.
2. There are remote chances of injury. However, appropriate tests will be performed to help identify if I may be predisposed to risk or injury.
3. I can at any time discuss with the physiotherapist and/or other clinical staff, the nature and purpose of treatments and their risks.
4. The results of treatment are not guaranteed. I will discuss the goals of my treatment with my practitioner.
5. The personal information that is gathered by this facility will be kept securely within the facility and used only for my health care needs.
6. I give the practitioner permission to assess my physical person and discuss/determine the appropriate course of treatment.

I have read and understood the above statement, accept the risk and hereby consent to all my present and future rehabilitation.

| | | |
|---|---|---|
| Patient name (please print) | Patient Signature (Parent/Guardian if < 16 yr) | Date |
| Witness (please print) | Witness Signature | Date |

PEAKCHIRO
MASSAGE + ACUPUNCTURE + PHYSIO

## INFORMED CONSENT FOR MASSAGE THERAPY TREATMENT

I understand that the Registered Massage Therapist is providing massage therapy services within their scope of practice as defined by the College of Massage Therapists of Ontario (CMTO).

I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.

I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that my massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third-party payers.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

| | | |
|---|---|---|
| Client Name (please print) | Client Signature<br>(Parent/Guardian if < 16 yr) | Date |
| Witness | Witness Signature | Date |

PEAKCHIRO plus
MASSAGE + ACUPUNCTURE + PHYSIO

## INFORMED CONSENT FOR TCM/ACUPUNCTURE TREATMENT

I hereby request and consent to the performance of acupuncture and, as needed, other procedures.

I understand that in the practice of acupuncture and other Traditional Chinese Medicine modalities, there are some risks including, but not limited to: minor bleeding/bruising, minor soreness, nausea, fainting, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles are used, which are disposed of after each use/treatment. I do not expect the doctor to be able to anticipate and explain all possible risks and complications.

I wish to rely on the acupuncture provider to exercise judgement during the course of treatment, which based on the facts then known, is in my best interest. I understand that the results are not guaranteed.

I have read the above consent form. I have had an opportunity to ask questions, and by signing below, I agree to the abovementioned procedures. I intend this consent form to cover the entire course of treatment for my present and future considerations and extend this consent to all acupuncture colleagues within this clinic.

Note to Female Patients: I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible.

☐ I hereby state that **I am not pregnant** nor is there any possibility that I may be pregnant. I also understand it is my responsibility to inform the doctor prior to treatment if I become pregnant in the future.

☐ I hereby state that **I am pregnant**. I also understand it is my responsibility to inform the doctor prior to treatment if I become pregnant again in the future.

| Patient name (please print) | Patient Signature (Parent/Guardian if < 16 yr) | Date |
|---|---|---|
| Witness (please print) | Witness Signature | Date |

PEAKCHIRO plus
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# FEE SCHEDULE

| | | | |
|---|---|---|---|
| **Chiropractic and/ or Acupuncture:** | | | |
| Consultation / Exam or Restart after 6+ months: | | Regular: | **$100** |
| | | Seniors (65+): | **$85** |
| Chiropractic Session: | | Regular: | **$66** |
| | | Extended Chiro (+ Acup): | **$80** |
| | | Seniors (65+): | **$58** |
| **Physiotherapy:** | | | |
| Consultation / Exam: | | Regular: | **$110** |
| | | Extended: | **$130** |
| Session: | | Regular (30min): | **$85** |
| | Extended: | 30min | **$95** |
| | | 45min | **$100** |
| | | 60min | **$120** |
| Pelvic Physiotherapy: | | Initial (60 min): | **$150** |
| | | Subsequent (45 min): | **$120** |
| **Registered Massage Therapy (HST Included):** | | 30 minutes: | **$77** |
| | | 45 minutes: | **$98** |
| | | 60 minutes: | **$123** |
| | | 90 minutes: | **$162** |

*Please read and kindly Initial your consent to the right:* *INITIAL:*

- *With your permission, we may be able to directly bill your Work Benefits* _____
- *We run a zero-balance clinic. Through your insurance benefits and /or yourself we kindly ask that your account balance be "zero" after each and every visit.* _____
- *We run an "on time" and by appointment clinic. Your time is important and so is ours. As such, we require 24 hours notice for appointment cancellations. Without 24 hours notice a cancellation fee of 50% of your scheduled services will be charged to you.* _____

_____

*Patient signature of Acknowledgement*

#14 - 9222 Keele Street, Vaughan, ON | www.PeakChiroPlus.com | 905-832-9596

# PATIENT PRIVACY CONSENT FORM

## FOR THE COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of our office providing you with quality health care. We understand the importance of protecting your personal information. We are committed to collecting, using and disclosing your personal information responsibility. We also try to be as open and transparent as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

In this office, **Dr. Nick J. Fava, B.Sc., D.C.** acts as the privacy information officer.

All staff members who come in contact with your personal information are aware of the sensitive nature of all the information you have disclosed to us They are all trained in the appropriate uses and protection of your information.

Attached to this consent form, we have outlined what our office is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information and / or pictures or images or testimonials with your consent;
- We share your pictures, images or testimonials (where you are identified) with your consent;
- Storage, retention and destruction of your personal information complied with existing legislation, and privacy protocols;
- Our privacy protocols comply with legislation standards of our regulatory bodies, the College of Chiropractors of Ontario, the College of Massage Therapists of Ontario, and the College of Physiotherapists of Ontario.

Do not hesitate to discuss our policies with me or any member of our office staff.

Please be assured that every staff person in our office is committed to ensuring that you receive the best quality health care.

**HOW OUR OFFICE COLLECTS, USES & DISCLOSES PATIENTS PERSONAL INFORMATION**

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing your information.

This office will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient patient care
- To identify and to ensure continuous high quality service
- To assess your health needs
- To provide health care
- To advise you of treatment options
- To enable us to contact you
- To establish and maintain communication with you
- To offer and provide treatment, care and services in relationship to your injury rehab and / or preventative / maintenance goals.
- To communicate with other treating health-care providers, including specialists and family medical doctors

- To allow us to maintain communication and contact with you to distribute health-care information and to book and confirm appointments
- To allow us to efficiently follow-up for treatment, care and billing
- For teaching and demonstrating purposes which is always on a anonymous basis
- To complete and summit health claims for third party adjudication and payment
- To comply with legal and regulatory requirements, including the delivery of patients' charts and records to the College of Chiropractors of Ontario, the College of Massage Therapists of Ontario, and the College of Physiotherapists of Ontario in a timely fashion, when required, according to the provisions of the *Regulated Health Professions* Act
- To comply with agreements/undertakings entered into voluntarily by the members with the College of Chiropractors of Ontario, the College of Massage Therapists of Ontario, and the College of Physiotherapists of Ontario, including the delivery and / or review of patients' charts and records to the Colleges in a timely fashion for regulatory and monitoring purposes
- To permit potential purchasers, practice brokers or advisors to elevate the health care practice
- To allow potential purchasers, practice brokers or advisors to conduct an audit in preparation for a practice sale
- To deliver your charts and records to the health insurance carrier to enable the insurance company access liability and quantify damages, if any
- To prepare materials for the Health Professions Appeal & Review Board (HPARB), if applicable
- To invoice for goods and services
- To process credit card payments
- To collect unpaid accounts
- To assist this office to comply with all regulatory requirements
- To comply generally with the law

**PATIENT CONSENT**

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information.

I know that your office had a Privacy Code, and I can ask to see the Code at any time.

I agree that Dr. Nick J. Fava and staff can collect, use and disclose personal information about

(patient name) _____ as set out above in the information about the office's privacy policies

_____ _____

Signature (patient, parent, or guardian) Print Patient Name

_____ _____

Date Signature of Witness