PATIENT INTAKE FORM

Name: ________________________________ M ☐ / F ☐ Date of Birth: _m__/_d__/__y__

Address: ______________________________ Apt.____ City: ___________ Postal Code: _____-_____

Home: (____) _____- _______ Cell: (____) _____- _______ Email: ______________________

Occupation: ______________________________ Employer ______________________________

Family Physician: Dr. ______________________________ Permission to Consult? Yes ☐ No ☐

Physicians Phone No. (____) _____-_______ Address: ______________________________

Main Interest For Today's Visit? ☐ Chiropractic ☐ Physiotherapy ☐ Massage ☐ Other ________________

Therapy Goals: ☐ Pain Relief ☐ Flexibility ☐ Core Strength/Endurance ☐ Improve Posture ☐ Weight Loss ☐ Maintenance

1) Primary Insurance: _______________ Group/Policy:_______________ ID: _______________

Policy Holder? ☐ Self ☐ Spouse ☐ Parent Name: _______________ DOB: _m__/_d__/__y__

2) Secondary Insurance: _______________ Group/Policy:_______________ ID: _______________

Policy Holder? ☐ Self ☐ Spouse ☐ Parent Name: _______________ DOB: _m__/_d__/__y__

Auto Accident Information

Insurance: ______________________________

Claim No. _______________ Accident Date _m__/_d__/__y__

Adjustor Name: ______________________________

(P) _______________ (F) _______________

WSIB Information

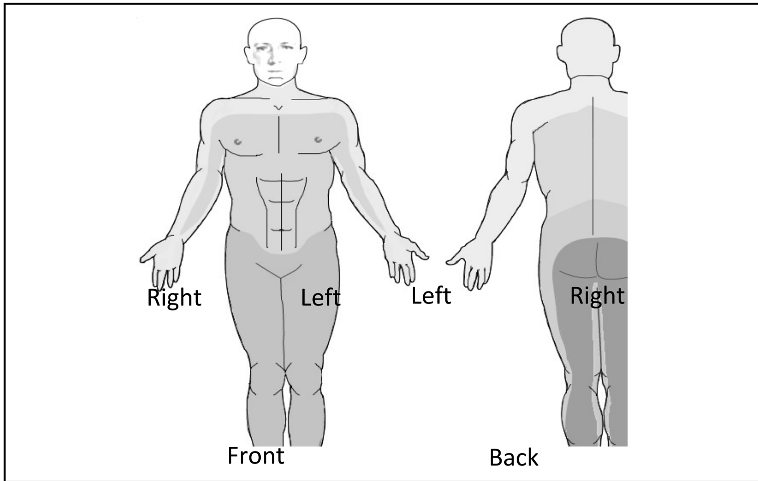
Is This a New Injury Claim? Yes ☐ No ☐

Claim No. _______________Accident Date __m__/_d__/__y__

Adjustor Name: ______________________________

(P) _______________ (F) _______________

In the diagram and using the symbols below mark the areas on your body that you feel best represents the location and type of pain or sensation you are **currently** experiencing.



0 ________________ 10

Place a vertical mark along the line to indicate your level of pain (0 being the least pain and 10 being the worst pain)

Tight/Stiff (**X**) Sharp (**/**)

Burning (**O**) Numbess (●)

Use the symbols above to indicate the type of pain or sensation you are currently experiencing

Please check the following health conditions/procedures that apply to <u>you</u>, both past (X) and present (✓)

☐ Abdominal Pain
☐ Arthritis
☐ Chronic Pain
☐ Diabetes
☐ Fatigue/Weakness
☐ Fracture
☐ Sensitivities/Allergies
☐ Ear Problems
☐ Headache/Migraine
☐ Heart Disease/Attack
☐ Hyper/Hypo-Tension
☐ Joint Pain/Stiffness
☐ Kidney Problems
☐ Low Back Pain
☐ Loss of Sensation
☐ Vison Loss/ Problems
☐ Muscle Cramps/Spasm
☐ Neck Pain/Stiffness
☐ Numbness/Tingling
☐ Osteoporosis
☐ Poor Circulation/Bruising
☐ Rheumatoid Arthritis
☐ Cancer
☐ Varicose Veins/Phlebitis
☐ Scoliosis
☐ Sciatica
☐ Spinal Cord Injury
☐ Sprain / Strain
☐ Stroke/Aneurysm
☐ Thyroid Disease
☐ Pacemaker
☐ Other __________

Infections: ☐ Hepatitis ☐ Skin Condition ☐ TB ☐ HIV ☐ Herpes ☐ Other Gynecological Infections ________

Respiratory: ☐ Chronic Cough ☐ Shortness of Breath ☐ Bronchitis ☐ Asthma ☐ Emphysema

Are you pregnant? ☐ No ☐ Yes How far along? ________ How is your general Health? ________________

Do you take any medications? No ☐ Yes ☐ ____

Surgery History? ____

Please check the health conditions that you apply to your <u>immediate family</u>, both past (X) and present (✓)

☐ Cancer ________________
☐ Heart Disease ___________
☐ Respiratory Problems _____
☐ Diabetes ________________
☐ Cholesterol _____________
☐ Arthritis ________________
☐ Stroke/Aneurysm ________________
☐ High Blood Press. ________________
☐ Other ________________

Clinic Policies

General Policy

Core Health Care ensures a fair and professional relationship toward all our patients and we ask that as a patient that you be considerate to the doctors, therapists, administration staff and fellow patients while attending our facility.

Information/Record Keeping Policy

Core Health Care requires certain information as it relates to your current condition and health history. All information provided will be kept strictly confidential, which includes all medical and health information and well as any personal and financial information that may be provided.

Cancellation Policy

Core Health Care enforces a strict cancellation policy to ensure that any given patient can receive the care they need on any given day. We require a **24 hour** notice for cancellation of any appointment. A fee of **50%** of the scheduled visit will be charge for missed appointments without a **24 hour** notification. This fee is not covered by insurance plans and thus must be paid at the patient's own expense.

Treatment Liability Waiver

Doctors of Chiropractic, Physiotherapists and Massage Therapist who use manual therapy techniques are required to advise patients that there are or may be some risks associated with such treatment. I understand and am informed that, as in the practice of medicine, there are some risks to treatment including, but not limited to the following;. Some patients may experience **short term aggravation of symptoms, rib fractures, muscle and ligament strains or sprains, bruising or disc herniations**, as a result of manual therapy techniques. While extremely rare, there are reported cases of **stroke** associated with many common neck movements including, chiropractic adjustment of the upper cervical spine. However, present medical and scientific evidence does not establish a definite cause and effect relationship between upper cervical spine adjustment and the occurrence of stroke. Chiropractic treatment has been demonstrated to be an effective treatment for many neck & back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. The risk of injuries or complications from chiropractic treatment and/or manual therapy is substantially lower than that associated with many medical or other manual treatments, medications and procedures given for the same symptoms. It is also common for patients to engage in physical exercise while attending the clinic's facilities, which could cause injury to the client. The client hereby states that he/she is and will be voluntarily participating in these activities and the client hereby assumes all risk of injury which might result from these activities.

Should your treatment plan require the need for custom orthotics you will be required to undergo a biomechanical assessment to further evaluate your condition and to determine the appropriate product required. You acknowledge there are or may be some risks associated with custom orthotics but not limited to, foot pain, leg pain or back pain. You do not expect Core Health Care to be able to anticipate all the risks and complications and wish to rely on the health practitioner to exercise good clinical judgment at the time of examination based on the facts then know.

Policy Agreement and Informed Consent

I have read, understand and agree to the clinic policy's set forth by Core Health Care to the best of my knowledge, I certify that the information provided in the above forms is accurate and that I will advise Core Health Care staff of any changes pertaining my personal information and relevant health history. I consent to the treatment offered or recommended to me by my health care provider and I intend this consent to apply to all my present and future care.

______________________________	______________________________	____________________
Patient Signature or Parent/Legal Guardian	Patient Name or Parent/Legal Guardian (Printed)	Date (m/d/y)

Payment Options and Acknowledgment

☐ Pay As You Go:

The patient will pay for services rendered and/or product received by Core Health Care. Payment is required upfront prior to the rendering of each service/product. Invoices and receipts will be provided to the patient and the patient will be responsible for submitting claims to their insurance for reimbursement, either electronically or via mail.

☐ Direct Billing: (Extended Health Care/ Motor Vehicle Accident /WSIB)

The patient allows Core Health Care to submit claims directly to insurance companies on behalf of the patient, provided electronic submission is available under the insurance policy. Payment for services rendered will be paid directly to the clinic by the patient's insurance provider (if applicable) and any unpaid balances (I.E) Co-Pays, Deductables, Coverage Limits Exceeded/Max Out, or Non-Eligible services/products) will be the responsibility of the patient. To ensure **full payment** is received by the clinic a **valid credit card number/information** is required on file so that Core Health Care may collect outstanding balances not paid in full by their insurance provider(s). Claims submission and all relevant paperwork will be facilitated by Core Health Care and all insurance and financial information provided to the clinic will be kept strictly confidential.

CREDIT CARD INFORMATION

_________________________	__________	__________	______________
Credit Card Number	*Type*	*3 digit CSC code*	*Expiry Date (M/YY)*

I have read and/or have been explained the payment options available to me, including all financial terms and conditions set out by Core Health Care and agree to abide by them. I understand that payment is expected in full for all services rendered and/or products ordered and I allow Core Health Care to charge my credit card for any outstanding balances on my account as set out in this policy. Invoices and receipts will be provided to me for any charges incurred on my credit card and that I may at any time request invoices for any services/products provided under my account.

________________________________	________________________
Patient or Parent/Legal Guardian Signature	*Date (M/D/YY)*