Patient Intake

PATIENT INFORMATION			
Name:	Gender:	☐ Male	☐ Female
Date of Birth (dd/mm/yy):	Todays Date (dd/mm/yy):		
Address	City:	Postal Code:	
Home Phone:	Work Phone:	Mobile Phone:	
Occupation:	Employer:		
Email :			
Health Card Number:			
Emergency Contact Information:			
Name:	Phone Number:		
Family Doctor Information			
Name:	Phone Number:		

Policies:

1. Please provide 24 hours notice of any cancellations
2. Late arrivals will be seen for the remainder of their appointment time only. It is our goal to stay on schedule to the best of our abilities
3. We do not accept tips under any circumstances.

Consent to Communicate with you via email/phone:

To remind you of the time and date of your appointment, we may contact you before an appointment.

I authorize you to contact me via email or phone for purposes related to my appointment:

_____ _____

Patient signature/Substitute decision maker Date

_____

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Please check the boxes for any conditions you have experiences or are experiencing

CARDIOVASCULAR	DISEASES/ CONDITIONS	BONE HEALTH	RESPIRATORY
☐ Anemia ☐ Chronic Heart Failure ☐ Heart Attack ☐ Heart Disease ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Pacemaker or similar devices ☐ Phlebitis/varicose veins ☐ Stroke/ CVA	☐ Allergies ☐ Cancer ☐ Diabetes ☐ Eczema/Psoriasis ☐ Epilepsy ☐ Hepatitis (A, B, C, or D) ☐ HIV/AIDS ☐ Tuberculosis ☐ Vertigo ☐ Any other communicable diseases or haemophilia? If so, please describe: _____ _____	**History of Bone Fractures** ☐ Yes ☐ No **Osteoporosis/Osteopenia** ☐ Yes ☐ No **Arthritis** ☐ Yes ☐ No **Head/Neck** ☐ Dizziness/ Double Vision ☐ Hearing Loss or Conditions ☐ History of Headaches ☐ History of Migraines ☐ Vision Loss/changes	☐ Chronic Cough ☐ Shortness of Breath ☐ Bronchitis ☐ Emphysema ☐ Asthma **PELVIC HEALTH** ☐ Yes ☐ No Other Conditions: ☐ Mental Health ☐ Digestive ☐ Organ Dysfunction ☐ Other (please specify): _____ _____

Current Medication(s):

_____

_____

Please list any previous surgical procedures and any details/hardware (le/prosthesis, wires, internal pins/fixators)

_____

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_____

Please list the names and contact information of any other health care practitioners that are participating in your care, and that you would like us to communicate with.

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