

New Patient Intake Form

Name: _____ Date of Birth (D/M/Y): _____ Sex: M F

Address: _____ City: _____

Province: _____ Postal Code: _____

Email: _____ Primary Phone #: _____

Email Appointment Reminders? Yes SMS Text Appointment Reminders? Yes

Emergency Contact: _____ Phone #: _____ Relationship: _____

Family Doctor: _____

Occupation: _____ How did you hear about us? _____

Claims and Insurance

Is your injury the result of a Motor Vehicle Accident (MVA)? Yes

Is your injury the result of a Workplace Accident (WSIB Claim)? Yes

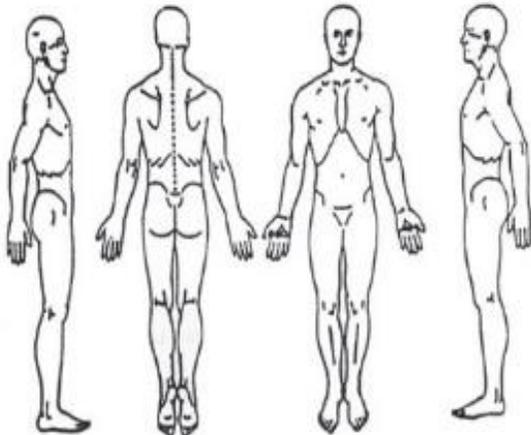
If you have Extended Health Coverage (EHC) and would like us to attempt Direct Billing for you, please complete **Benefit Assignment Electronic Transmission Authorization and Consent Form**.

Current Health Complaint

Current Concern(s): _____

On the diagram below please use the symbols to mark which best represents your complaint:

Numbness	=====	Pins & Needles	*****
Burning	XXXXXX	Stabbing & Sharp	////////////////
Dull & Achy	+++++++	Stiff & Tight	2222222



Rate your pain (10 is the worst): _____ / 10

When did it start? _____

How did it start? _____

Does it travel? _____

Have you experienced it before? _____

Have you received treatment for it before? _____

Describe: _____

What aggravates your condition? _____

What relieves your condition? _____

Secondary Concerns and other comments: _____

Medical History

Medical Conditions you have been diagnosed with:

Current Medications:

Vitamins & Supplements:

Any family history of major medical conditions? (eg. cancer, blood pressure, stroke, heart attack, arthritis, etc.)

Past surgeries (*include dates if known*):

Past car accidents (*include dates if known*):

Past trips, falls, and other injuries (*include dates if known*):

Please indicate any other health conditions you experience:

- Allergies? *If yes, specify:* _____
- Bruise Easily
- Vision Problems
- Hearing Problems
- Are you currently pregnant? *If yes, due date:* _____
- Do you smoke? *If yes, how much:* _____

Please indicate your typical level of physical activity:

- Minimal (eg. light housework, occasional walking)
- Mild (eg. walks daily, yardwork / home maintenance)
- Moderate (eg. biking, swimming, focused home exercise, routine strengthening / stretching)
- High (eg. running, gym 2-3x per week, recreational sports, fitness classes)
- Strenuous (eg. gym 4-7x per week, competitive sports, athlete)

Other: _____