Patient Intake Form

Date:

Full Name: Age:

Address: City:

Best Contact Number: Postal Code:

Email: Emergency Contact:

How would you like to be contacted for appointments? ☐ Cell ☐ Home ☐ Work ☐ Email

Date of Birth: (MM/DD/YY) ☐ Male ☐ Female

Employer: Occupation:

Do you have Extended Health Insurance? ☐ YES ☐ NO Provider:

Family Doctor Name: Number:

Date of Last Doctor Visit: Reason:

As a professional courtesy our clinic may send a progress letter to your family doctor.
Do we have your permission to do so? ☐ YES ☐ NO

Is your condition due to: ☐ Car Accident? ☐ Workplace Injury? ☐ Personal Injury?

Date of Injury: Metal Implants? (pins, wires) ☐ YES ☐ NO

Please list any surgical procedures/hospitalizations/car accidents:

Please list any medications and reasons for taking them:

How did you hear about our clinic? Please be specific:

Are you seeing anyone for your current condition?

Have you ever had? ☐ Physiotherapy ☐ Chiropractic ☐ Massage Therapy ☐ Naturopathy ☐ Acupuncture ☐ Chiropody ☐ Shockwave ☐ Other____________________________

Privacy Policy: Personal health information is collected and managed at Maple Health Care & Rehab in accordance with the Personal Health Information Protection Act (PHIPA). For more information please ask your health care provider, or go to www.ipc.on.ca.

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Please check any of the following that apply:

☐ Diabetes - Type 1 or 2 ☐ Epilepsy ☐ Allergies - to what:

☐ Arthritis ☐ Osteoporosis ☐ Cancer - type:

☐ HIV/AIDS ☐ Tuberculosis ☐ Hepatitis

☐ Liver Disorder ☐ Polio ☐ Gall Bladder Disorder

☐ Skin Condition: ☐ Other:

Cardiovascular: ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Stroke

☐ Heart Disease ☐ Blood Clots ☐ Pacemaker

☐ Bleeding Problems ☐ Phlebitis ☐ Varicose Veins

Respiratory: ☐ Asthma ☐ Emphysema

☐ Pneumonia ☐ Bronchitis ☐ Chronic Cough

☐ Shortness of Breath ☐ Other:

Other: ☐ Headaches ☐ Migraines

☐ Vision Problems/Loss ☐ Contact Lenses ☐ Hearing Loss

☐ Depression ☐ Psychological Condition:

Family History Of: ☐ Heart Disease ☐ Stroke

☐ Diabetes ☐ Arthritis ☐ Other:

Women's Health: Are You Pregnant? ☐ YES ☐ NO ☐ Gynaecological Conditions

Lifestyle: Do You Smoke? ☐ YES ☐ NO Do You Drink Alcohol? ☐ YES ☐ NO

Do You Exercise Regularly? ☐ YES ☐ NO Do You Stretch Regularly? ☐ YES ☐ NO

Do You Eat Well? ☐ YES ☐ NO Are You Interested In Losing Weight? ☐ YES ☐ NO

What Are Your Goals For Treatment? ☐ Pain Relief ☐ Increased Flexibility

☐ Increased Strength ☐ Increased Energy ☐ Better Digestion

☐ Healthy Eating ☐ Wellness Care ☐ Healthy Aging

☐ Stress Relief ☐ Other:

Please list any other health issues or information which may be helpful in our care for you:

I hereby confirm that all information I have supplied is accurate and complete

Signature:____**Date:**______________________________