

PATIENT INTAKE INFORMATION

Name: _____ Today's Date _____

Health Card #: _____ Date of Birth: (MM/DD/YYYY): _____

Address: _____ City/Postal Code: _____

Home # _____ Bus # _____ Cell # _____

Occupation: _____

Do you give us permission to contact you by text message? Yes No

Do you give us permission to contact you by email? Yes No - email address: _____

Is this a SGI claim? Yes No Is this a WCB claim? Yes No

Emergency Contact Name: _____ Contact #: _____

In detail, describe your chief complaint: _____

Using the appropriate symbol below, please mark the area on your body where you feel the described sensation:

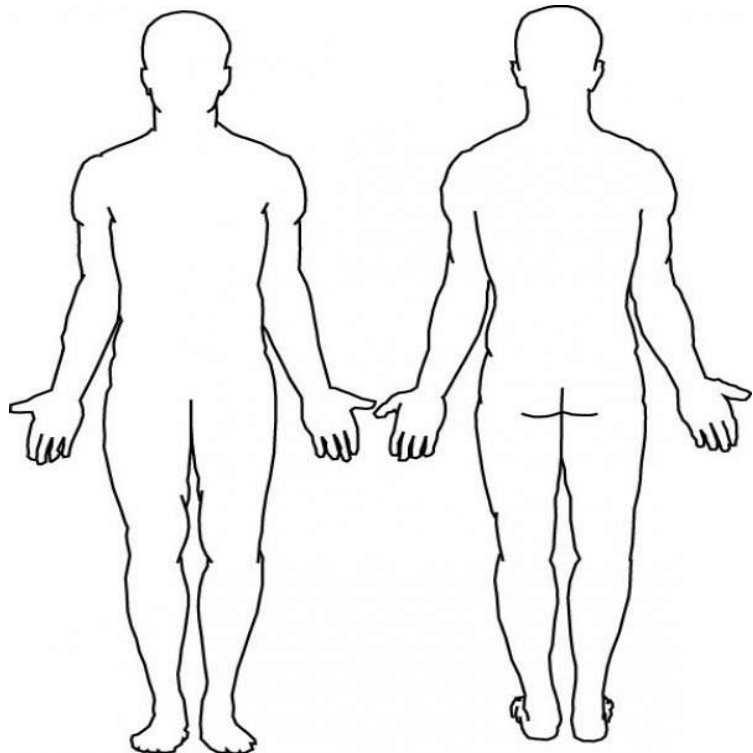
Aching pain ((
Burning pain x x x
Stabbing pain ///

Pins & needles +++
Numbness = = =

How long have you had these symptoms?

Are you currently off work? _____

Are you currently working restricted hours or restricted duties?



Your most recent visit to:

Medical Doctor: Name: _____ Date: _____

Chiropractor: Name: _____ Date: _____

Massage Therapy: Name: _____ Date: _____

Physiotherapy: Name: _____ Date: _____

Have you had recent?

X-rays: area of body: _____ where/when: _____

Ultrasound: area of body: _____ where/when: _____

CT scan: area of body: _____ where/when: _____

MRI: area of body: _____ where/when: _____

Circle current health issues:

- | | | |
|-----------------|----------------|----------------------------------|
| Alcoholism | Anemia | Arteriosclerosis & heart disease |
| Arthritis | Emphysema/COPD | Anxiety |
| Diabetes | Gout | Pneumonia |
| Rheumatic Fever | Tuberculosis | Ulcers |
| Asthma | Stroke | Epilepsy |
| Cancer | | High Blood Pressure |

Do you smoke? Yes No if so, how much do you smoke per day? _____

Alcohol consumption per week: _____

List major surgeries you've had in the last 10 years: _____

Height: _____ Weight: _____

PLEASE RETURN PAPERWORK TO FRONT DESK