



# Patient Intake

Welcome to Functional Innovative Therapeutics aka. FIT. Please fill-out the following form as complete as possible, circling a response where necessary. Accurate demographic information is important to ensure high-quality care, and effective communication. If your demographic information changes, please let us know. All demographic information is strictly confidential except as required or allowed by law.

## Patient Demographic Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Gender: F M T  
 DOB: (day, month, year) \_\_\_/\_\_\_/\_\_\_\_\_ Age: \_\_\_\_\_  
 Marital Status: single common-law married seperated divorced widowed  
 Number of children: \_\_\_\_\_  
 Address: \_\_\_\_\_ Apt # \_\_\_\_\_  
 City: \_\_\_\_\_ Postal Code: [ ][ ][ ][ ][ ][ ][ ][ ][ ]  
 Telephone: (home) [ ][ ][ ]-[ ][ ][ ]-[ ][ ][ ][ ] (mobile) [ ][ ][ ]-[ ][ ][ ]-[ ][ ][ ][ ]  
 Email 1: \_\_\_\_\_ 2: \_\_\_\_\_  
 Occupation: \_\_\_\_\_ Employed: Full Time Part Time  
 Employer: \_\_\_\_\_ (work) [ ][ ][ ]-[ ][ ][ ]-[ ][ ][ ][ ] Ext: \_\_\_\_\_

## Emergency Contact

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Telephone #1: [ ][ ][ ]-[ ][ ][ ]-[ ][ ][ ][ ] #2 [ ][ ][ ]-[ ][ ][ ]-[ ][ ][ ][ ]

## Family Physician

Name: \_\_\_\_\_ Telephone: [ ][ ][ ]-[ ][ ][ ]-[ ][ ][ ][ ]

## Referral Source:

<input type="checkbox"/> <b>Medical Referral</b>	Dr. Name: _____ Telephone: [ ][ ][ ]-[ ][ ][ ]-[ ][ ][ ][ ]
	Address: _____ Fax: [ ][ ][ ]-[ ][ ][ ]-[ ][ ][ ][ ]
	City: _____ Postal Code: [ ][ ][ ][ ][ ][ ][ ][ ][ ]
<input type="checkbox"/> <b>WSIB</b>	Claim Number: _____
<input type="checkbox"/> <b>MVA</b>	Claim Number: _____
<input type="checkbox"/> <b>Referral (Family or Friend)</b>	Name: _____
<input type="checkbox"/> <b>Walk in or from the gym</b>	
<input type="checkbox"/> <b>Other:</b>	_____

## A Few Questions

- May we give you reminder calls? Y N
- May we leave you phone messages? Y N
- Would you like to be added to our email list for our newsletter and information about upcoming events? Y N

Please Continue →



# HEALTH HISTORY FORM

**For your information:**

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please let us know. All information for treatment is confidential, except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Primary Complaint**

Description	When did it start?	How did it happen?
<i>i.e. Chronic low back pain</i>	<i>10 years ago</i>	<i>I strained my back playing golf</i>

**Health History:** Please circle all current conditions and x any past condition. Indicate the diagnosis in the space

**Respiratory**

- chronic cough
- shortness of breath
- bronchitis
- asthma
- emphysema
- Frequent colds (#/ year \_\_\_\_\_)

**Cardiovascular**

- High blood pressure or hypertension
- low blood pressure
- Heart attack (when: \_\_\_\_\_)
- Stroke (when: \_\_\_\_\_)
- chest pain / angina
- difficulty breathing
- pacemaker
- phlebitis
- vascular disease \_\_\_\_\_

**Skin Condition**

- Skin condition \_\_\_\_\_

**Genitourinary**

- painful urination
- unusual colour / odour of urine
- loss of bladder control
- painful sex

**Other Conditions**

- osteoporosis
- prolonged steroid use
- Inflammatory disease \_\_\_\_\_
- collagen disease \_\_\_\_\_
- diabetes (onset: \_\_\_\_\_)
- allergies
- cancer or tumours \_\_\_\_\_
- arthritis
- sleeping disorder \_\_\_\_\_

**Infection**

- hepatitis
- skin conditions
- TB
- HIV / AIDS
- STD (what: \_\_\_\_\_)  
(when: \_\_\_\_\_)

**Symptoms**

- loss of sensation (where: \_\_\_\_\_)
- fatigue / tiredness
- nausea
- constipation
- diarrhea
- rapid weight loss
- appetite changes
- loss of mental concentration
- Leg pain / weakness / tingling
- Arm pain / weakness / tingling

**Head/Neck**

- Headaches
- Head injury
- Whiplash
- Vision problems
- ear problems
- concussion
- Dizziness
- oral or dental problems or injuries

**Soft Tissue / Joint Discomfort**

- neck \_\_\_\_\_
- low back \_\_\_\_\_
- mid back \_\_\_\_\_
- upperback \_\_\_\_\_
- shoulder \_\_\_\_\_
- arms \_\_\_\_\_
- legs \_\_\_\_\_
- hands \_\_\_\_\_
- Feet \_\_\_\_\_

**Lifestyle**

- smoking (cig / day \_\_\_\_\_)
- alcohol (drinks / week \_\_\_\_\_)
- exercise (times / week \_\_\_\_\_)

**Other medical conditions** (e.g. digestive conditions, gynaecological conditions, hemophilia, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Surgeries and Medical Procedures:

List all past surgeries or medical procedures in the space provided

When	Procedure	Purpose
<i>i.e dec 93</i>	<i>right knee menisectomy</i>	

### Medication:

If you have an up-to-date list of medication you are currently taking, please hand-in this list with the intake and skip this step

Medication	Purpose	Amount	duration
<i>i.e. vioxx</i>	<i>anti-inflammatory</i>	<i>10 mg 3 x day</i>	<i>2 weeks</i>

**Of Special Note:** (presence of internal pins, wires, artificial joints, special equipment):

\_\_\_\_\_

\_\_\_\_\_

**Present involvement in other Health Care:** YES NO (please circle)

If yes, please specify: \_\_\_\_\_

\_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date \_\_\_\_\_ Reviewed by: \_\_\_\_\_

## Office Policies

Thank you for choosing Functional Innovative Therapeutics for your musculoskeletal health needs. To provide the best health care possible we have developed the following office policies.

Our multidisciplinary health care professional team includes chiropractic physicians, massage therapists, kinesiologists, and physiotherapists. All treatments rendered will be rendered by the appropriate registered health care professional, or under the direct supervision of the appropriate health care professional. Please check with your extended health care plan administrator to see if your treatment is covered. You are required to sign the daily-sign in sheet prior to any treatment.

All information for treatment is confidential, except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Initial Chiropractic or Physiotherapist visits are \$75.00 and follow-up sessions are \$60.00. Massage therapists visits are \$50.00 for 1/2 hour and \$85.00 for an hour. **You are required to pay for each session at the time of your visit.** Payment may be made by cash, Interac, cheque (payable to Functional Innovative Therapeutics), Mastercard, or Visa. Prices are subject to change without notice. If you prefer to pay after several treatments, you can opt to have a balance with the clinic. With this option it is required that you leave an imprint of a valid major credit card with the clinic. Balances will be automatically cleared from your account monthly. You can choose to have the balance cleared either on the **15th** or **25th** of each month. Patients with health insurance should remember that services rendered are charged to you, not your insurance company.

Attending your therapy appointments is important to your rehabilitation. Lateness of 15 minutes or more is considered a missed appointment, and the appropriate fees will be applied. Charges for missed therapy or physician appointments or cancellations without 24 hour notice will be invoiced to your account, emergencies notwithstanding. This fee is **\$25.00**.

If payment is delayed, reduced or denied, you will be responsible for settling your balance with us.

**I verify that I have read and understand the above and agree to follow the terms and conditions outlined.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Patient's Name (Please Print): \_\_\_\_\_