TRANQUIL THERAPEUTIC SOLUTIONS
Health & Wellness Centre

PATIENT INTAKE FORM

Name: ____ Date Of Birth: ______________

Street: ____ Apt _______

City: ____ Province: ________ Postal Code: ______________

Home: (_____) ______-___________Work: (_____) ______-___________ Cell: (_____) ______-___________

Email address: ____ Marital Status: ☐S ☐M

The clinic requires your permission to call you at home and/or your place of business and to leave messages. Please indicate your preference: ☐ Home ☐ Business ☐ Either

We offer newsletters and email notifications with useful health information and updates on changes in the clinic. Would you like to receive this information? (Y/N)_______

How did you hear about us: ____

Employer: ______________________________________ Occupation: ____________________________

Family Physician: _______________________________ Permission to Consult: ☐Y ☐N **INITIAL**: ______

Physician's Phone: (____) _____-_________ Address/Street: ______________________________________

Extended Health Company name: ____

Group No: _________________ Certificate/Identification No: ______________________________________

If Health Coverage is under another family member: Name of Family Member:____________________

Health History: (please mark all current and past symptoms)

Please indicate conditions you are experiencing or have experiences:		
GENERAL		
Cardiovascular [ ] High blood pressure [ ] Low blood pressure [ ] Congestive heart failure [ ] Heart attack [ ] Phlebitis/Varicose veins [ ] Stroke/CVA [ ] pacemaker or similar device [ ] Heart disease	**Infections** [ ] Hepatitis [ ] Skin conditions [ ] TB [ ] HIV [ ] Herpes	**Head/Neck** [ ] History of headaches [ ] History of migraines [ ] Vision problems [ ] Vision loss [ ] Ear problems [ ] Hearing loss
Respiratory [ ] Chronic cough [ ] Emphysema [ ] Bronchitis [ ] Asthma [ ] Shortness of breath	**Other Conditions** [ ] Loss of sensation, where? __________________________ [ ] Skin conditions, what? __________________________ [ ] Diabetes, onset:___________ [ ] Cancer, where? ___________	[ ] Allergies/hypersensitivity to what? ____________________ [ ] Epilepsy [ ] Arthritis Is there a family history of arthritis? [ ] Yes [ ] No

MUSCLES / JOINTS / NERVES		
[ ] Back pain	[ ] Migraine Headache	[ ] Dizziness/vertigo
[ ] Hip pain	[ ] Scoliosis	[ ] Loss of co-ordination/balance
[ ] Knee pain	[ ] Sciatica	[ ] Degenerating discs
[ ] Ankle/foot pain	[ ] Arm pain/weakness/tingling	[ ] Vision problems
[ ] Fractures/dislocations	[ ] Leg pain/weakness/tingling	[ ] Hearing problems/Tinnitus
[ ] Tension Headache	[ ] Head trauma/concussion	
Do you have internal pins, wires, artificial joints or special equipment? [ ] Yes [ ] No	What? ______________________ Where?_____________________	

HABIT		
[ ] Smoking: _______ packs/day	[ ] Alcohol: ________ glass/day	[ ] Exercise: ________x/week

WOMEN
[ ] Pregnant, due:_________________
[ ] Gynecological conditions, what? ____
Overall, how is your general health? ____
Primary Care Physician:_________________________

Are there any other symptoms or conditions that you currently have or had in the past that are not listed above? If so, please list them:

____

What medications/supplements are you taking? ____

Please list any present or past significant trauma (car accident, falls, etc…):

____

Have you had any surgeries? ☐Y ☐N What? ____________________________ When? ______________

Have you ever received any of the following services? If yes, please indicate your last appointment date:

☐ Physiotherapy/Rehabilitation ☐ Massage Therapy ☐ Chiropractic Treatment

What is your major complaint? (Purpose of this appointment): ____

How long have you had this condition? ______________ Have you had this condition before? (Y/N): _______

What caused your complaint to begin? ____

Where do you feel it most? ☐ Right Side ☐ Left Side ☐ Equal Both Sides

Describe your pain: ☐ Dull ☐ Achy ☐ Burning ☐ Numb ☐ Pins & Needles

What activities / positions make your condition worse? ____

What activities / positions make your condition better? ____

Major Surgeries / Operations: ____

Do you have any other concerns that you would like to address? If so, please detail them here:

In the diagram provided below, please mark the areas on your body that you feel best represent the pain(s) or sensations(s) you are **currently** experiencing. Please include all areas. Use the symbols provided below.

Symbols:

Numbness //////
//////

Stabbing or ‖ ‖ ‖ ‖
Sharp ‖ ‖ ‖ ‖

Dull Ache ++++
++++

Burning xxxx
xxxx

Stiff & ====
Tight ====

Please place a vertical mark along the line below to indicate how bad you feel your pain is today:

No Pain **Worst Pain Imaginable**

I____I

0 *10*

Health Goals:

1. On a scale of 1 – 10, how healthy do you feel you are? _________

2. Do you feel that you can or should change any of the following areas of your life?

[ ] Pain/Discomfort	[ ] Energy Level	[ ] Posture
[ ] Weight problem	[ ] Stress	[ ] Muscle Tone
[ ] Physical Fitness	[ ] Flexibility	[ ] Quit Smoking
[ ] Core Muscle Strength	[ ] Nutritional Habits	

3. Do you have any habits that negatively affect your health?

[ ] Pain/Discomfort	[ ] Energy Level	[ ] Posture
[ ] Weight problem	[ ] Stress	[ ] Muscle Tone
[ ] Physical Fitness	[ ] Flexibility	[ ] Quit Smoking

4. On a scale of 1 – 10, how important is it to you to improve your health? _________

I certify that the information above is accurate. I will advise the Doctor or Therapist if my condition changes

Patient Signature: ____ **Date:** ________________

Guardian (if under 18): ____ **Date:** ________________

Cancellation Policy I understand that if I do not provide with 4 hours notice of a cancellation, I may be charged the **FULL FEE** of my appointment to my account for time lost. This charge is not covered by my Extended Health Care Benefits. I have read, been explained, and I agree to the cancellation policy. *Initial here* _____________

INFORMED CONSENT As a matter of ethics and laws, there is an obligation prior to examination and treatment to disclose any material risk to the patient in order to obtain a valid informed consent. As part of the Physiotherapy, Osteopathy, Chiropractic and Massage Therapy treatments, certain procedures and devices may be utilized such as the use of heat, ice, electrotherapy, acupuncture, laser and manual therapy.

As part of the rehabilitation program, certain testing procedures, devices, and equipment may be utilized by members of the rehabilitation team (assistant/aide, or kinesiologist) such as weight machines, exercise, cardiovascular work and functional tasks.

I have had the opportunity to discuss with the Doctor and/or other clinical staff, the nature and purpose of treatments. I understand the results are not guaranteed. I further understand, and I am informed, that there are some slight risks to treatments, including, but not limited to, muscle strains, sprains, disc injuries, and burns. I have been made aware that there are remote possibilities of injury and that appropriate tests will be performed to help identify if I may be susceptible to risk or injury.

I have read and understood the above statement. By signing below I agree to the above mentioned treatment procedures and accept the risk, and hereby consent to treatment.

Client Name: ______________________________________ Date: _________________________

Client Signature: ___________________________________