#306-1777 56th street
Delta V4L 0A6
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PATIENT INTAKE FORM

The information contained within this form is considered completely confidential.
Your responses are extremely important to help us better understand you and the health issues that you may be experiencing and will ensure the delivery of the best possible treatment for you.

NAME : _____

ADDRESS:_____

_____ POSTAL _____

HOME #_____ **MOBILE #**_____

E-MAIL_____ **OCCUPATION:** _____

BIRTHDAY: _____ **PHN:** _____

AGE: _____ **GENDER:** MALE FEMALE NON-IDENTIFYING

EMERGENCY CONTACT: NAME:_____

PHONE#_____

RELATIONSHIP: _____

FAMILY DOCTOR: NAME: _____

PHONE#_____

HOW DID YOU HEAR ABUT US? _____

MEDICAL QUESTIONNARE

Please check each line that is associated with the corresponding health concern you have or have had.

__ **NONE**

__ Fatigue
__ Depression
__ Tension Headaches
__ Migraines
__ Dizziness
__ Fainting
__ Loss Of Sleep
__ Nervousness
__ Irritability
__ Excitability
__ Weight Loss/Gain
__ Ringing Of The Ears

__ Bruise Easily
__ Varicose Veins
__ Hives
__ Dryness
__ Eczema
__ Psoriasis
__ Skin Graft
__ Measles
__ Chickenpox
__ Mumps

__ Asthma
__ Allergies
__ Chronic Cough
__ Hay Fever
__ Shortness Of Breath
__ Wheezing

__ Neck Pain
__ Mid Back Pain
__ Low Back Pain
__ Muscle Weakness
__ Joint Dislocation
__ Joint Separation
__ Bone Fracture
__ Bursitis
__ Gout
__ Rods/Pins/Plates _____
__ Spinal Injury _____
__ Surgical Reconstruction _____
__ Surgical Repair _____
__ Arthritis - Osteoarthritis
__ Arthritis - Rheumatoid

__ Hemorrhoids
__ Chronic Nausea
__ Heart Burn
__ Ulcers
__ Diverticulitis
__ Chronic Constipation
__ Chronic Diarrhea
__ Gallbladder Trouble
__ Hernia _____
__ Irritable Bowel Syndrome
__ Colitis

__ Crohn's Disease
__ Celiac Disease

__ High Blood Pressure
__ Low Blood Pressure
__ High Cholesterol
__ Irregular Pulse
__ Palpitation
__ Poor Circulation
__ Rapid Heart Beat
__ Slow Heart Beat
__ Swelling Of Ankles
__ Heart Disease
__ Heart Attack
__ Pace Maker
__ Shunts
__ Stroke
__ Aneurysm
__ Heart Condition
__ Circulatory Condition
__ Blood Clot (DVT)
__ Anemia
__ Appendicitis
__ Bronchitis
__ Emphysema
__ Severe Allergy/Anaphylaxis
__ Polio
__ Rheumatic Fever
__ Multiple Sclerosis
__ Tuberculosis
__ Hypothyroidism
__ Hyperthyroidism
__ Seizures/Epilepsy
__ Osteopenia
__ Osteoporosis
__ HIV/AIDS
__ Hepatitis_____
__ Diabetes Type 1
__ Diabetes Type 2

__ Corrective Lenses - Glasses
__ Corrective Lenses - Contacts

__ Surgical Implants
__ Surgical Removal

__ Cancer - Past _____
__ Cancer - Present _____
__ Chemotherapy - Past _____
__ Chemotherapy - Present _____
__ Radiation - Past _____
__ Radiation - Present _____

Have you been hospitalized for any major illnesses, surgeries or accidents?
Please explain _____
_____
_____
_____
_____

Any strains, sprains or broken bones? Please explain _____
_____
_____
_____
_____

Have you been in a car accident in the last 10 years?
Please explain _____
_____
_____
_____
_____

Please list all medications that you are currently taking:
_____
_____
_____
_____
_____
_____

Do you have any other health concerns that your therapist should be aware of? _____
_____
_____
_____
_____

WOMEN ONLY

__ Congested Breasts
__ Hot Flashes
__ Menopause
__ Irregular Periods
__ Birth Control

Are you pregnant? Y N
If so, how many weeks? ____

WHAT BRINGS YOU IN TODAY? Please describe your current condition and symptoms that you feel

_____

_____

_____

OTHER TREATMENT AND/OR THERAPY (please specify)

__ Physiotherapy
__ Acupuncture
__ Naturopathic Medicine
__ Nutritionalist
__ Chiropractic
__ Massage Therapy
__ Other
__ NONE

CHECK THE BOXES THAT APPLY TO YOU

SLEEP QUALITY
__ Poor
__ Moderate
__ Good

ENERGY LEVEL
__ Poor
__ Moderate
__ Good

ACTIVITY LEVEL
__ Poor
__ Moderate
__ Good

STRESS LEVEL
__ Low
__ Moderate
__ High

HOURS OF SLEEP
__ 3-5 hours
__ 6-8 hours
__ 9 or more

__ SMOKER
__ NON-SMOKER

ANY SPECIFIC ALLERGIES OR SENSITIVITIES THAT WE SHOULD BE AWARE OF?

_____

FAMILY HISTORY

Please check and indicate the specific condition and which family member diagnosed

__ High Blood Pressure _____

__ Diabetes Type 1 _____

__ Diabetes Type 2 _____

__ Heart Disease _____

__ Stroke _____

__ Arthritis _____

__ Kidney Disease _____

__ Lung Disease _____

__ Liver Problems _____

__ Stomach/Bowel Disorders _____

__ Neurological Disorders _____

__ Psychiatric Disorders _____

__ Genetic Disorders _____

__ Congenital Disorders _____

__ Cancer _____

We understand that this is sensitive and private information.
Our clinic is a multi-disciplinary clinic and the information needed to perform treatments accurately depends on the Practitioner having a full history of the patient. Please rest assured knowing that we keep all records confidential between the Practitioners only.

CONSENT FORM

Please check the box for each required consent and sign below

ACCURACY OF INFORMATION

☐ **(REQUIRED)** I CERTIFY THAT THE ABOVE MEDICAL INFORMATION IS CORRECT TO MY KNOWLEDGE

PRIVACY AND SHARING OF INFORMATION

☐ **(REQUIRED)** I AUTHORIZE THE CLINIC AND ITS ASSOCIATED HEALTH PROFESSIONALS TO COLLECT MY PERSONAL AND MEDICAL INFORMATION AS DOCUMENTED ABOVE. IN ADDITION, I AUTHORIZE THE CLINIC AND ITS ASSOCIATED HEALTH PROFESSIONALS TO COMMUNICATE WITH MY FAMILY DOCTOR AND/OR REFERRING DOCTOR AS DEEMED NECESSARY FOR MY BENEFICIAL TREATMENT. I ALSO UNDERSTAND THAT MY PERSONAL AND MEDICAL INFORMATION IS CONFIDENTIAL AND WILL ONLY BE DISCLOSED TO THIRD PARTIES WITH MY PERMISSION.

CANCELLATION POLICY

YOUR APPOINTMENT TIME IS RESERVED JUST FOR YOU. A LATE CANCELLATION OR MISSED VISIT LEAVES A HOLE IN THE THERAPISTS DAY THAT COULD HAVE BEEN FILLED BY ANOTHER PATIENT. AS SUCH, WE REQUIRE 24 HOURS NOTICE FOR ANY CANCELLATIONS OR CHANGES TO YOUR APPOINTMENT. PATIENTS WHO PROVIDE LESS THAN 24 HOURS NOTICE, OR MISS THEIR APPOINTMENTS, WILL BE CHARGED A CANCELLATION FEE.

☐ **(REQUIRED)** I AM AWARE OF THE CANCELLATION POLICY

CONSENT TO TREATMENT

☐ **(REQUIRED)** I CONSENT TO THE PERFORMANCE OF EXAMINATION AND TREATMENT ON ME BY THE PRACTITIONERS THAT ARE ENGAGED IN PRACTICE AT VIP THERAPY.

☐ **(REQUIRED)** I UNDERSTAND THAT MY CARE MAY INVOLVE JUDGEMENT BASED UPON FACTS AND INFORMATION KNOWN TO THE PRACTITIONER. THE PRACTITONER WILL USE THIS JUDGEMENT TO ATTEMPT TO ANTICIPATE AND EXPLAIN RISKS AND COMPLICATIONS OF TREATMENTS PERFORMED. AN UNDESIRABLE RESULT DOES NOT NECESSARILY INDICATE AN ERROR IN JUDGEMENT AND NO GUARANTEE FOR RESULTS CAN BE MADE OR EXPECTED.

☐ **(REQUIRED)** I FURTHER UNDERSTAND THAT THERE ARE CERTAIN DEGREES OF RISK ASSOCIATED WITH TREATMENT. I CHOOSE TO RELY ON THE PRACTITIONER TO RECOMMEND THE BEST COURSE OF TREATMENT THAT IS IN MY BEST INTEREST.

_____ _____

(signature of patient or guardian) (printed name)

_____ _____

(name of patient if a minor) (date signed)