Inside Out

Patient/Client Intake Form

The following information needs to be gathered in order for us to formulate a safe and effective treatment plan for you. This information will be kept confidential and cannot be released without your written consent unless obliged by law. This information may be shared amongst other health information custodians or circle of care for the purpose of your health care. Please feel free to ask any questions about the information being requested.

Last Name:_____ Name: _____ Gender: M __ F __Date Of Birth: _____
(mm/dd/yyyy)

For Office Use Only
Driver's License Number: _____ Photo Id: Y ___ N___

Address: _____ Apt: _____ City: _____
Postal Code: _____ Home Phone: _____Bus: _____

Cell: _____ Email: _____ Occupation: _____

Who May We Thank For Referring You To Our Care? _____
Name of family member, friend, co-worker, internet, yellow pages, street sign etc.
Are You Currently Seeing A Health Professional For Your Condition? Yes/No,
Please Explain: _____

HEALTH HISTORY (PLEASE CHECK ANY CONDITIONS THAT APPLY TO YOU)

RESPIRATORY	**CARDIOVASCULAR**	**GENERAL**
☐ Chronic Cough	☐ High Blood Pressure	☐ Headaches
☐ Shortness of breath	☐ Low Blood Pressure	☐ Vision Problems
☐ Smoker	☐ Poor Circulation	☐ Ear Aches
☐ Asthma	☐ Heart Disease	☐ Epilepsy
☐ Chronic Bronchitis	☐ Phlebitis	☐ Sinus Problems
☐ Other	**MUSCLES AND JOINTS**	☐ Allergies
DIGESTIVE/URO-GENERAL	☐ Stiffness	☐ Frequent Colds
☐ Poor Appetite	☐ Swelling	☐ Chronic Pain
☐ Constipation	☐ Limitation in Movements	☐ Chronic Fatigue
☐ Liver/Gallbladder	☐ Back Pain	☐ Dizziness
☐ Kidney/Bladder	☐ Shoulder Pain	☐ Other
☐ Difficult Digestion	☐ Neck Pain	**WOMEN**
☐ Diabetes	☐ Pain in Limbs	☐ PMS
☐ Hernia	☐ Pin & Needles in Limbs	☐ Menopause
☐ Ulcer	☐ Rheumatoid Arthritis	☐ Pregnant
SKIN	☐ Osteoarthritis	**OTHER**
☐ Sensitive Skin	☐ Whiplash	☐ Cancer/Tumors
☐ Rashes/Eruptions	**INJURIES FROM ACCIDENTS**	☐ Depression
☐ Cold Sore	☐	☐ HIV & AIDS
☐ Warts	☐	

How much of the following substances do you use on a daily basis? Tobacco:____Alcohol:_____Coffee:_____
Recreational Drugs: _____
Do you exercise: Yes:_____ How often? _____ No:_____
(Please discuss with your practitioner any concerns you may have that are not listed above.)

PAST HEALTH HISTORY

PLEASE DESCRIBE:

Major Surgery/Operations, type: _____ Date: _____

Previous: Childhood Traumas: _____ Sports Injuries: _____

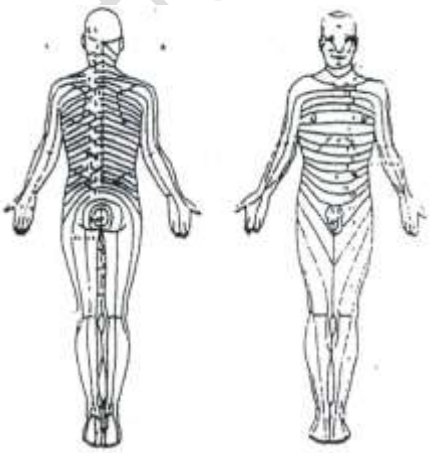
Motor Vehicle Accidents: _____Work Injuries: _____

Pins, wires, or plates? _____

Current Medications & Conditions Treated: _____

INDICATE ANY OF THE FOLLOWING AILMENTS THAT HAVE AFFECTED YOUR RELATIVES:

Alcoholism	Allergies	Arthritis	Asthma	Cancer	Depression
Diabetes	Epilepsy	Gonorrhea	Gout	Hay fever	Heart Disease
Rheumatoid	Paralysis	Pneumonia	Skin Disease	Syphilis	TB



Please outline on the diagram the area of your discomfort XXX and any radiation///

I agree to inform my practitioner of any concerns/changes to the status of my condition(s)and any changes to my health.

I understand that InsideOut Wellness Centre can provide courtesy notification for my appointments via text, e-mail or telephone. It is my responsibility to note the time and date of all my appointments. I understand that a minimum of 24 hours notice is required to change or cancel my appointment.

I understand that fees charged for the service are due when the service is rendered.

I understand that the information that I give on this form will be strictly confidential and will be kept very private in accordance with The Registered Health Practitioners Act and Privacy Legislation.

Practitioners/Therapist Name: _____

Patient/Guardian Signature: _____Date: _____

Most services are covered by Extended Health Insurance. Please check with your benefits administrator at work.

45-3560 Rutherford Road, Woodbridge, ONT. L4H 3T8 Tel. 905-303-4622