WHAT TO BRING TO YOUR FIRST VISIT

 SPINEgroup Intake Forms & Outcome Measures

 Medication/Vitamin List / Drug Allergies
Make a list of any medications and vitamins you are currently taking including dosages and frequency. Include a list of any drug allergies you may have.

 Motor Vehicle Insurance Information
Please bring your insurance company information, including the claim number, policy number and adjuster name and contact information. Bring any correspondence from your insurance company. Briefly describe and illustrate details of your accident, i.e. intersection, speed, size of vehicle, # of passengers.

 Workers Compensation (WSIB) Information
Bring the claim number, adjuster name and contact information and any correspondence from WSIB.

 Doctor Referral
If your insurance company requires a physician's referral for massage therapy, physiotherapy or for assistive devices such as orthotics or compression stockings please bring the referral to the clinic.

 X-rays, MRI Scan, CT Scan, Other Studies
Please make certain you bring any x-rays, MRI scans, CT scans, etc., as well as any radiology reports. Bring all studies that have been done within 6 months or related to your injury or condition.

CLINIC POLICIES

Our policies are designed to promote quality care and maintain optimal relationships with patients.

Information and Record Keeping

SPINEgroup is responsible for the privacy of all patient data and information. We will not disclose any medical information to any third party (except as may be required by other health professionals involved with your care or as required by law) without written consent from the patient. No medical information about you may be given over the phone, including laboratory or diagnostic results.

Cancellations or Missed Appointments

SPINEgroup enforces a strict cancellation policy to ensure sufficient time for patient services is provided each day. We require a 48 hour (2 day) notice during regular office hours for any appointment cancellation. This ensures that we have adequate time to fill the time slot for another patient. A fee will be charged to your account for all missed appointments without the required notice period. Cancellations for emergency circumstances will be considered if you reschedule your appointment at your earliest convenience.

Financial Policy

All services rendered are paid for at the time of service unless an alternative arrangement has been made with clinical director. Medical services: patients must provide a valid (non-expired) OHIP card at every visit. In the event of an expired card, patients will be billed directly for services. We provide all patients with receipts of payment for submission to insurance companies but cannot bill directly to 3rd party coverage insurers (with the exception of WSIB and Motor Vehicle Insurers.) Payment options include cash, debit or Visa. Please call for cost of initial examination.

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Patient Intake Form:

Patient Full Name _____Age_____ □ Male □ Female

Date of Birth: D_____/M_____/Y_____ Marital Status: S M W D Sep

OHIP #_____ Version Code_____

Street Address _____ City _____ Province_____

Postal Code _____ Home Phone Number (_____) _____ Cell # (_____)_____

Work Number (_____)_____ Email Address_____

How did you hear about us? □ Phone Book Sign Physician Referral Friend □ Website □ Other_____

Employer _____Occupation_____

Patient's Family Doctor _____ Phone # (_____)_____

Name of Spouse or Parent (if minor)_____

Is this a work-related injury? □ Yes □ No Is this a motor vehicle accident Injury? □ Yes □ No

Motor Vehicle Insurance Company: _____
MVA/WSIB Information:

Claim #_____ Policy # _____

Case Manager/Adjuster Name:_____ Contact Number (_____)_____

Date of Accident: D_____/M_____/Y_____

Policy Holder's Name _____ Relationship to Patient _____

Legal Representative: _____ □ Lawyer is Not Involved
Phone: (_____)_____ Fax: (_____)_____

Do you have Extended Health Coverage? □ Yes □ No Do you have secondary coverage? □ Yes □ No

Primary Extended Health Insurance Company: _____

Policy #_____ Employee ID# _____

Policy Holder's Name _____ Relationship to Patient _____

Policy Holder's Date of Birth: D_____/M_____/Y_____

AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS, REFUND & CANCELLATION POLICY

I hereby consent and authorize payments of WSIB, personal injury, extended health insurance and MVA insurance claim benefits to Dr. Connie D'Astolfo Chiropractic Professional Corporation ("SPINEgroup™") for all health services, rendered or to be rendered in the future, without obtaining my signature on each such claim. I also authorize the release of any medical information by Spinegroup to others necessary as required for treatment, billing purposes and medical research and/or clinical educational purposes. I UNDERSTAND I AM PERSONALLY RESPONSIBLE AND LIABLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be PERSONALLY responsible for any collection and reasonable legal fees, interest and costs.

SPINEgroup enforces a strict cancellation policy to ensure sufficient time for patient services is provided each day. We require a 48 hour (2 day) notice during regular office hours for any appointment cancellation. This ensures that we have adequate time to fill the time slot for another patient. A fee will be charged to your account for all missed appointments without the required notice period. There are no refunds for supplements, clinical services and prepaid services, assessments and programs.
I HAVE READ AND UNDERSTOOD THE POLICIES AND PROCEDURES.

X_____ Date_____
Patient/Parent/Guardian Signature

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Clinical Information:

Current Complaints/Medical Diagnoses: _____

_____

How did condition/injury occur?

_____

Date of injury or date symptoms appeared D_____/M_____/Y_____

Have you ever had same condition? If yes, when? _____

List of other health professionals seen for this injury/condition_____

Have you ever had surgery or been hospitalized? ☐ Yes ☐ No If yes, please list below with dates:

_____

_____

_____

Do you use tobacco: ☐ No ☐ Yes If yes, how much and how long?

_____

Do you use alcohol? ☐ No ☐ Minimal ☐ Moderate ☐ Heavy ☐ Previous user

Do you exercise? ☐ Daily ☐ Regularly ☐ Weekly ☐ Occasionally ☐ Never

Do you use an assistive device (cane, walker, wheelchair, etc): ☐ No ☐ Yes

Are you currently working? ☐ Yes ☐ No ☐ Retired

If yes, what are your job duties?

_____

_____

Allergies: _____

Current Medications or Supplements: Please List

Name of Drug/Supplement	Dose/Frequency of Use	Reactions

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Check off if you have been diagnosed or suffered with any of the following in the last 12 months:

☐ Alcoholism	☐ Irregular Heartbeat	☐ Depression or Anxiety
☐ Diabetes	☐ Indigestion	☐ Tuberculosis
☐ Ankle Swelling	☐ Diarrhea	☐ Extremity Pain, Numbness or Tingling
☐ Ear Pain/Ringing	☐ Kidney Stones	☐ Back or Neck Pain
☐ Bleeding Problems	☐ Asthma	☐ Cancer _____
☐ Blood Clots in Legs	☐ High Blood Pressure	☐ Stomach Ulcers
☐ Bloody Stools	☐ Vision Problems	☐ Nose Bleeds
☐ Bowel Incontinence	☐ Dizziness/Fainting	☐ Osteopenia or Osteoporosis
☐ Chest Pain	☐ Loss of Weight	☐ Shortness of Breath
☐ Chronic Cough	☐ Headaches	☐ Night Sweats
☐ Constipation	☐ Hepatitis	☐ Stroke
☐ Heart Attack	☐ Seizures	☐ Bladder Incontinence
☐ Swollen Joints	☐ HIV	☐ Muscle Weakness
Other:_____		

Females Only: Is There a Chance You Could Be Pregnant? ☐ **Yes** ☐ **No**

Average # of days of menstrual cycle _____ **Menopausal?** ☐ **Yes** ☐ **No**

Clinician Area:

Vitals:

Height: _____inches _____cm Weight: _____lbs _____Kg BMI _____

Blood Pressure R_____/_____ Glucose_____ Respiration:_____ Pulse Rate_____

L _____/_____

Reflexes: UE LE Grip Strength: R_____lbs L_____lbs

Psychological Screen: _____ SI Issues: ☐ Yes ☐ No

Notes:

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Please read each item below and indicate whether it is a symptom you are currently experiencing by circling "yes" or "no".

1	I have been depressed or down almost every day in the past two weeks.	YES	NO
2	I have lost interest in things that I used to enjoy.	YES	NO
3	I am sleeping *considerably more OR considerably less* (circle one) lately.	YES	NO
4	I am more irritable lately.	YES	NO
5	I am crying or want to cry more lately.	YES	NO
6	My life is in a rut and I worry that it will not get better.	YES	NO
7	My energy is considerably lower lately.	YES	NO
8	I have been feeling down or low for two or more years now.	YES	NO
9	I have been feeling (or recently felt) unusually hyper and energetic.	YES	NO
10	I have been feeling considerably anxious or frightened lately.	YES	NO
11	I experience a least one of the following on a regular basis: heart pounding, sweating when not hot, shakiness, shortness of breath, feeling out of control.	YES	NO
12	I seem to worry a lot about little things.	YES	NO
13	When I worry, I cannot shut off (or move on from) the worry thoughts.	YES	NO
14	I am having thoughts or impulses that I cannot get rid of, even though I try.	YES	NO
15	I worry about what other people think about me and this worry keeps me from going out or socializing at times.	YES	NO
16	I get very worried or uncomfortable when I am in small and/or crowded spaces.	YES	NO
17	I often think that there is something wrong with my body or that I have an illness.	YES	NO
18	I have experienced a traumatic event and I am still having difficulty dealing with it.	YES	NO
19	My use of substances and/or alcohol is creating trouble in my life.	YES	NO

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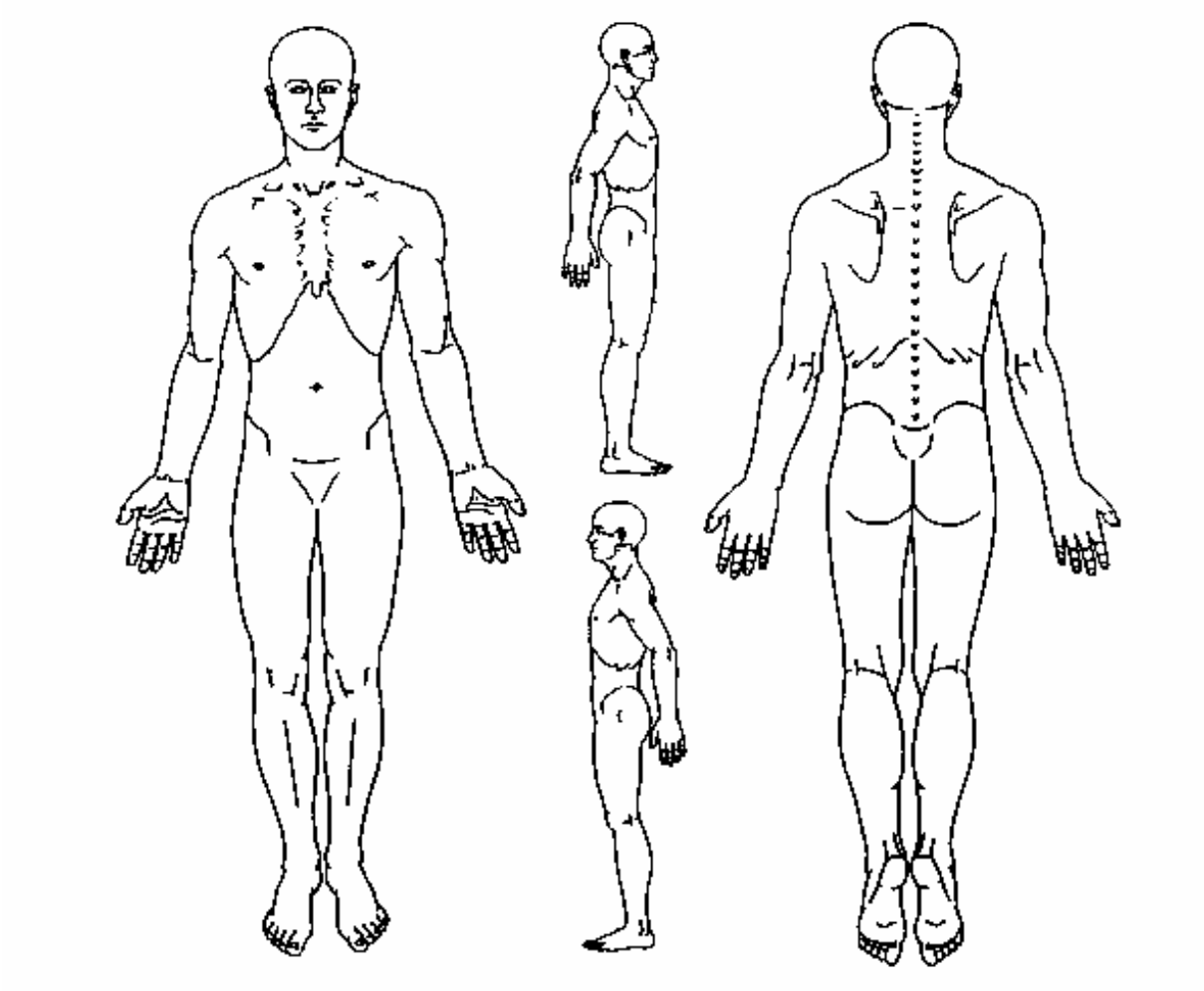
PAIN DIAGRAM

Please indicate where you are experiencing pain on the diagram. Use the symbols below to describe your pain.

(Do not indicate pains which are not related to your present injury or condition)

vvvv = Aching/Dull
oooo = Pins and needles
xxxx = Burning
//////// = Stabbing/sharp
==== = Numbness



Visual Analogue Scale: 0_____10
(Pain Scale)

Please mark your level of pain along the scale (0= no pain, 10= the worst pain)

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SPINEgroup

INFORMED CONSENT & PERMISSION TO DISCLOSE HEALTH INFORMATION

I. We are seeking **Informed Consent** for the health services we provide including: chiropractic, private physiotherapy, publicly-funded physiotherapy, massage therapy, podiatry, nursing, dietary, psychological, naturopathic, medical, and/or acupuncture services. Your treating health provider(s) within your "circle of care" are authorized to share your **Personal Health Information** ("PHI") for the purpose of collaborative management of your care. We always use all reasonable efforts to ensure privacy when entering your PHI in our common e-health record or EMR system such that your PHI information is not misunderstood, misused or lost by any health provider who may have access to your electronic patient chart.

II. Requests for services will begin with an initial clinical assessment. Feedback will be provided with suggestions given as to the course of treatment in terms of type, provider, length, plan and general approach. Referrals to other professionals outside the clinic may be made. Any changes in the type of treatment service to be provided in the future will be discussed with you in advance.

III. Only pre-sterilized needles are used. All acupuncture needles are properly disposed of after each and every treatment.

IV. There are risks and possible risks associated with orthopedic evaluation, functional assessments, acupuncture, manual therapy, mechanical traction, use of rehabilitation equipment and rehabilitation conducted by doctors of chiropractic, physiotherapists, acupuncturists, massage therapists or registered nurses. In particular, you should note:

a) While rare, some patients may experience aggravation of symptoms or muscle and ligament strains or sprains, bruising or irritation as a result of manual therapy, injection therapy, shockwave therapy, rehabilitation, acupuncture or in rare circumstances; orthopedic or functional evaluation. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures, including spinal manipulation.
b) I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding, or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.
c) Recent studies, etc. suggest that patients may be consulting medical doctors, nurses, physiotherapists, and chiropractors when they are in the early stages of a stroke (a stroke already in progress). You are being informed of this reported association because a stroke may cause serious neurological impairment or even death. The possibility of such injuries occurring in association with cervical manipulation is extremely remote and occurs infrequently. Please inform your treating provider immediately if you experience any unusual neurological symptoms, severe head, jaw and/or neck pain.
d) There are rare reported cases of disc or spinal injuries identified following cervical and lumbar spinal manipulation, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal manipulation. In some circumstances, manual therapy/spinal manipulation may aggravate an already existing degenerative disc condition.
e) There are infrequent reported cases of burns or skin irritation in association with the use of some types of ultrasound, electrical therapy, shockwave and laser therapy.

V. There are possible risks associated with assessments or counseling (nursing, chiropractic, occupational, vocational or psychological) including, the rousing of upsetting feelings. You are encouraged to advise your health provider if these should arise.

VI. There are risks associated with rehabilitation and the use of rehabilitation or exercise equipment at the facility. Risks include but not limited to muscle/ligament straining and falls, even under supervision. Vestibular and stability training through the use of therapy balls, rocker boards, vibration therapy, etc. pose a risk for falls thus proper footwear and padded environment must be maintained. The clinic provides rubber flooring in the rehab area and mats for protection. The patient assumes risk of injury when undergoing rehabilitation/exercise therapy.

VII. Disclosure of Personal Health Information: *Confidentiality and Privacy is respected at all times.* Sessions with all healthcare providers at SPINEgroup® and the information discussed are **confidential**; that is, the contents of a session, or even whether or not you attend, will not be revealed to outside sources unless you have given written consent/permission to do so, or as required by law. You maintain the right to review your PHI and patient file (which will be held in a secure location for a minimum of 10 years, after the last date of contact or 10 years after a patient's 18th birthday). Exceptions to confidentiality include the legal and/or ethical obligations to report as follows:

a) Inform a potential victim of violence of a client's intention to harm (if you are in, or appear to be in imminent danger of doing serious harm to yourself or another person);

b) Inform an appropriate family member, health care professional or police if necessary of a client's intention to end his or her life;
c) If there is reasonable suspicion based on your report that you or anyone else (under the age of 16) may be or have been a victim of physical, sexual and/or emotional abused by anyone, the appropriate children's aid society will be informed;
d) Report a health professional who has sexually abused a client/patient;
e) Release of a client/patient file if there is a court order or summons court attendance and/or for a production of your records;
f) As part of ongoing consultation, training, education, billing or research our providers may discuss or present the particulars of your case with other health professionals or insurers related to your treatment plan. With respect to publishable research and educational purposes, any information that would enable one to identify you will be de-identified. Statutory Accident Benefit claims require disclosure of health information (resulting from the motor vehicle accident as well as pre-existing conditions) to insurers, health professionals and social workers involved in your claim. Finally, professional Colleges conduct random Quality Assurance and it is possible that patient files will be disclosed to them if they initiate this process or a similar process.

VIII. Payment Policy: Payment for assessments and therapy is normally expected at each session (Cash, VISA, MASTERCARD, Debit, etc.) unless an alternate arrangement has been made with Clinical Director (with the exception of WSIB and Motor Vehicle Insurance Claims). In this way, the account remains manageable and your therapy becomes a naturally budgeted expense. Receipts will be given when payment is received. Please retain these receipts for your insurance or income tax claims, if applicable. SPINEgroup does not guarantee supplements, orthotics, braces, or any assistive mobility device.

IX. Cancellation Policy: Payment is expected for any missed session, unless the appointment is cancelled **at least forty-eight (48) business hours** in advance. If you arrive more than twenty (20) minutes late for an appointment, you will be charged the full session fee. In accordance with the professional fees and billing practices, overdue accounts will be charged interest rates of 1.5% monthly. If payment becomes a concern, please discuss it with the clinical director or clinic manager to avoid service charges for late payment or more active efforts to secure overdue statements.

SIGNED CONSENT

☐ **I consent to disclosure of my PHI to treating health providers at SPINEgroup who are involved in my care. Your signature indicates you have reviewed our *Informed Consent & Permission to Disclose Health Information* form about the potential risks of assessments, treatments and rehabilitation; the collection, use and disclosure of personal information, steps taken to protect the information and your right to review your personal information. You understand that, as explained herein, there are some rare exceptions to these commitments.**

☐ **I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my health provider the nature and purpose of my treatment in general, benefits and risk of treatment, alternate treatment options and recommendations for my condition, payment and cancellation policies and all the contents of this Consent. I have been given a chance to ask any questions about assessment and treatment risks and they have been answered to my satisfaction. I consent to the interdisciplinary treatment recommended to me by my provider including any recommended assessments, evaluations, rehabilitation, physical medicine, manual therapy, medical or naturopathic services and counseling services provided by any of the clinicians at SPINEgroup as listed in Section I**.

→ Email Address: _____ [optional]

☐ I further agree to receive SPINEgroup's newsletters containing news, updates and health promotions regarding SPINEgroup's health services and products. You can later withdraw your consent at any time by sending an email to info@spinegroup.ca.

☐ I also intend this Informed Consent to apply to all my present and future care at Spinegroup Health Clinic.

Date_____

_____ **Patient Signature (Legal Guardian)**

_____ **Witness/Signature**

Print Name:_____

Print Name: _____

Patient Consent to Release Personal Health Information

I consent to SPINEgroup® releasing the following information to the Ministry of Health and Long Term Care (the "Ministry") as of the date indicated below:

Patient Information: [Please Print]

1. Last Name:_____ First Name:_____ Middle Name:_____

2. Date of Birth: _____
   [YYYY---MM---DD]

3. My Ontario health card number: _____

4. A description of the physiotherapy service(s) provided to me by physiotherapy providers at my physiotherapy clinic as of the date indicated below, and

5. The date(s) on which these service(s) are provided to me.

I understand that I can withdraw my consent by contacting SPINEgroup at (905) 850-7746 and that if I withdraw my consent I will be required to pay the Clinic directly for services that the Clinic provides to me as a patient following the withdrawal of consent.

Patient Signature:

☐ I am signing on my behalf

☐ I am signing as a parent, or person who is lawfully entitled to give or refuse consent, on behalf of a child who is under 16

☐ I am signing as the guardian of the person, or attorney for personal care of an incapable adult

Name: _____
[Please Print]

Signature: _____ Date: _____
[YYYY---MM---DD]

Please provide your contact telephone number if you are signing on behalf of a child, or an incapable adult: _____