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_______ Social Insurance Number _____-______-____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

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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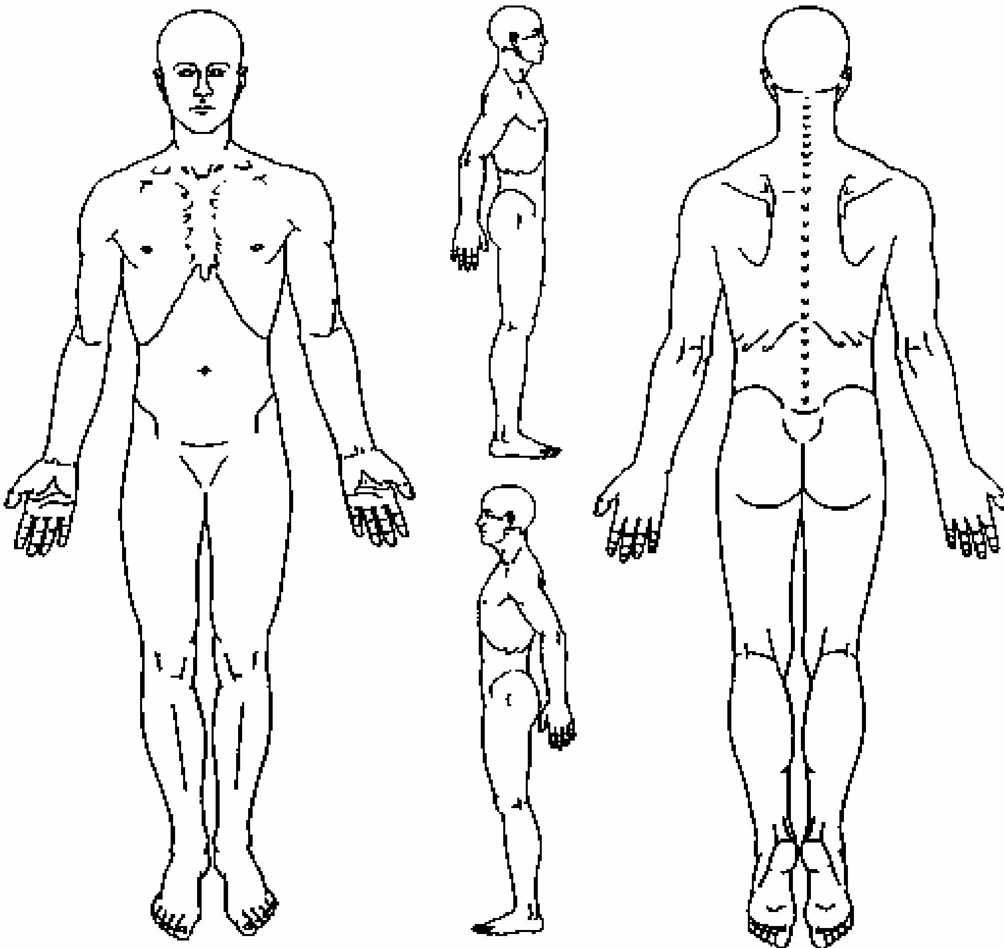
PAIN DIAGRAM

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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NECK DISABILITY INDEX

YOUR NAME (PRINT) ____________________________ **DATE**___________________________________

Please circle **ONE** answer in each section that most clearly describes your NECK problem. Mark only ONE in each section.

0. I have no pain at the moment.
1. The pain is mild at the moment.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain is severe but comes and goes.
5. The pain is severe and does not vary much.

0. I can look after myself without causing extra pain.
1. I can look after myself normally but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help but I manage most of my personal care.
4. I need help every day in most aspects of self care.
5. I do not get dressed, wash with difficulty and stay in bed.

0. I can lift objects without pain.
1. I can lift heavy objects but it causes extra pain.
2. Pain prevents me from lifting heavy objects off of the floor but I can if they are conveniently positioned, for example, on a table.
3. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
4. I can lift very light objects.
5. I cannot lift or carry anything at all.

0. I can read as much as I want to with no pain in my neck.
1. I can read as much as I want with slight pain in my neck.
2. I can read as much as I want with moderate pain in my neck.
3. I cannot read as much as I want because of moderate pain in my neck.
4. I cannot read as much as I want because of severe pain in my neck.
5. I cannot read at all.

0. I have no headaches at all.
1. I have slight headaches which come infrequently.
2. I have moderate headaches which come infrequently.
3. I have moderate headaches which come frequently.
4. I have severe headaches which come frequently.
5. I have headaches almost all the time.

0. I can concentrate fully when I want to with no difficulty.
1. I can concentrate fully when I want to with slight difficulty.
2. I have a fair degree of difficulty in concentrating when I want to.
3. I have a lot of difficulty in concentrating when I want to.
4. I have a great deal of difficulty in concentrating when I want to.

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5. I cannot concentrate at all

0. I can do as much work as I want to.
1. I can only do my usual work, but no more.
2. I can do most of my usual work, but no more.
3. I cannot do my usual work.
4. I can hardly do any work at all.
5. I cannot do any work at all.

0. I can drive my car without neck pain.
1. I can drive my car as long as I want with slight pain in my neck.
2. I can drive my car as long as I want with moderate pain in my neck.
3. I cannot drive my car as long as I want because of moderate pain in my neck.
4. I can hardly drive my car at all because of severe pain in my neck.
5. I cannot drive my car at all.

0. I have no trouble sleeping.
1. My sleep is slightly disturbed (less than 1 hour sleepless).
2. My sleep is mildly disturbed (1-2 hours sleepless).
3. My sleep is moderately disturbed (2-3 hours sleepless).
4. My sleep is greatly disturbed (3-5 hours sleepless).
5. My sleep is completely disturbed (5-7 hours sleepless).

0. I am able to engage in all recreational activities with no pain in my neck at all.
1. I am able to engage in all recreational activities with some pain in my neck.
2. I am able to engage in most, but not all, recreational activities because of pain in my neck.
3. I am able to engage in a few of my usual recreational activities because of pain in my neck.
4. I am not able to engage in most of my recreational activities because of my neck pain.
5. I cannot do any recreational activities at all.

TODAY MY NECK PAIN IS: (CIRCLE ONE)

0 1 2 3 4 5 6 7 8 9 10

MILD **SEVERE**

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OSWESTRY DISABILITY INDEX (LOW BACK PAIN)

YOUR NAME (PRINT) ______________________________ **DATE**________________________________

Please circle **ONE** answer in each section that most clearly describes your BACK problem.

0. I can tolerate my pain without using pain killers.
1. My pain is bad but I manage without taking pain killers.
2. Pain killers give me complete relief from my pain.
3. Pain killers give me moderate relief from my pain.
4. Pain killers give me very little relief from my pain.
5. Pain killers have no effect on my pain and I do not use them.

0. I can look after myself normally without causing extra pain.
1. I can look after myself normally but it causes extra pain.
2. It is painful to look after myself and I am slow and careful.
3. I need some help but I manage most of my personal care.
4. I need help every day in most aspects of self care.
5. I do not get dressed, wash with difficulty and stay in bed.

0. I can lift heavy objects without extra pain.
1. I can lift heavy objects but it gives extra pain.
2. Pain prevents me from lifting heavy objects off of the floor, but manage if they are conveniently positioned.
3. Pain prevents me from lifting heavy objects but I can manage light to medium objects if they are conveniently positioned.
4. I can only lift very light objects.
5. I cannot lift or carry anything at all.

0. Pain does not prevent me from walking any distance.
1. Pain prevents me from walking more than 1 mile.
2. Pain prevents me from walking more than ½ mile.
3. Pain prevents me from walking more than ¼ mile.
4. I can only walk using a cane or crutches.
5. I am in bed most of the time and have to crawl to the toilet.

0. I can sit in any chair as long as I like.
1. I can only sit in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. Pain prevents me from sitting at all.

0. I can stand as long as I want without extra pain.
1. I can stand as long as I want but it gives me extra pain.
2. Pain prevents me from standing more than 1 hour.
3. Pain prevents me from standing more than ½ hour.

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4. Pain prevents me from standing more than 10 minutes.
5. Pain prevents me from standing at all.

0. Pain does not prevent me from sleeping well.
1. I can sleep well only by taking medication for sleep.
2. Even when I take medication, I have less than 6 hours sleep.
3. Even when I take medication, I have less than 4 hours sleep.
4. Even when I take medication, I have less than 2 hours sleep.
5. Pain prevents me from sleeping at all.

0. My social life is normal and causes me no extra pain.
1. My social life is normal but increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests like dancing, etc.
3. Pain has restricted my social life and I do not go out as often.
4. Pain has restricted my social life to my home.
5. I have no social life because of pain.

0. I can travel anywhere without pain.
1. I can travel anywhere but it gives me extra pain.
2. Pain is bad but I manage journeys over 2 hours.
3. Pain restricts me to journeys of less than 1 hour.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain prevents me from traveling, except to the doctor or hospital.

0. My pain is rapidly getting better.
1. My pain fluctuates, but is definitely getting better.
2. My pain seems to be getting better, but improvement is slow at present.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TODAY MY BACK PAIN IS: (CIRCLE ONE)

0 1 2 3 4 5 6 7 8 9 10

MILD ... **SEVERE**

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