WHAT TO BRING TO YOUR FIRST VISIT

 SPINEgroup Intake Forms

 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.

 Physician Referral
If you are an OHIP physiotherapy patient or your *private insurance company* requires a physician's referral for massage therapy, physiotherapy or for assistive devices such as orthotics or compression stockings please bring the **physician 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________ Expiry Date____________________

Street Address ____ City ___________________ Province________

Postal Code ____________ Home Phone Number ____________________ Cell # __________________________

Work Number ________________________ Email Address_______________________________________

How did you hear about us? Online/Website Sign Physician Referral Friend/Family Ad/Article 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.

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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 ______/______ Muscle Strength Left UE____________ Left LE______________

O2 Saturation______________________ Right UE___________ Right LE______________

Reflexes: Left UE______________Left LE______________ Right UE____________ Right 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".

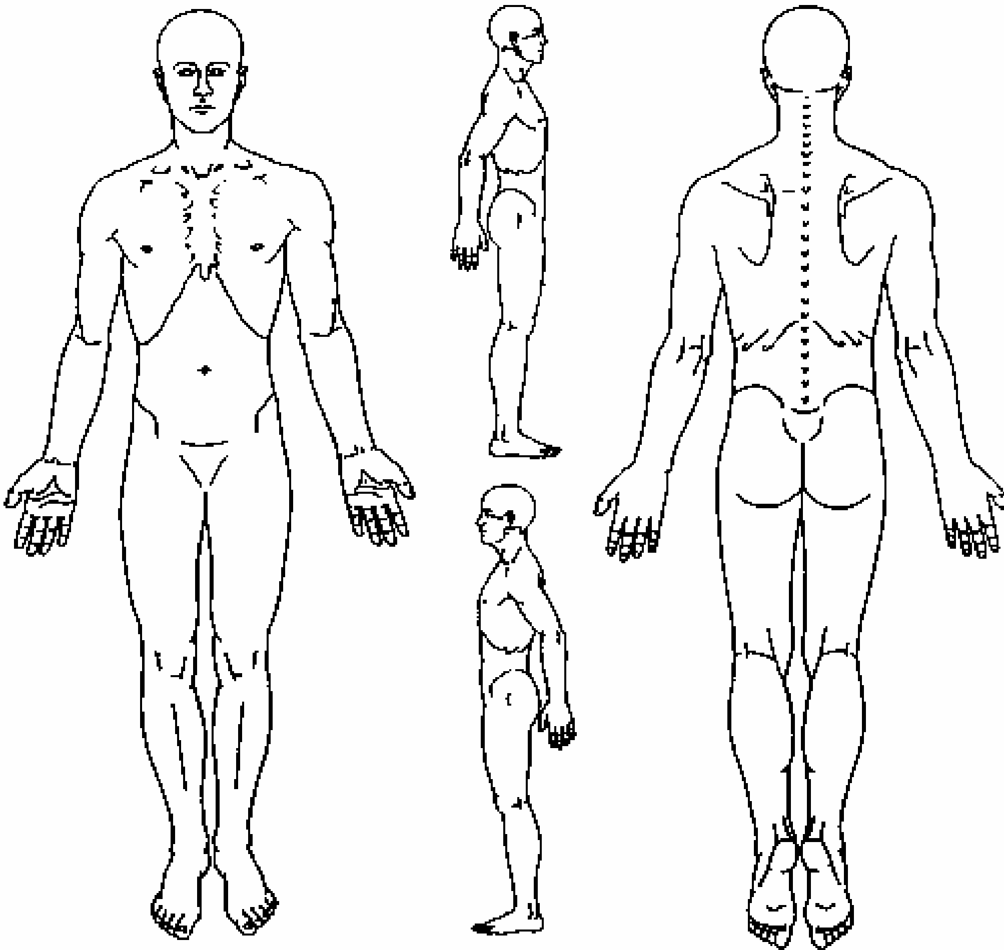
1	I have been depressed or down almost every day in the past two weeks.	YES	NO
2	I have lost interest in things that I used to enjoy.	YES	NO
3	I am sleeping *considerably more OR considerably less* (circle one) lately.	YES	NO
4	I am more irritable lately.	YES	NO
5	I am crying or want to cry more lately.	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

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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