CompleteCare CHIROPRACTIC

OSTEOPATHIC INTAKE

Date: _____

Welcome,

We can't explain how excited we are that you're taking the first steps towards a healthier you. At Complete Care Chiropractic, we pride ourselves on customer service and quality care so that we can provide our patients with the best possible experience. At Complete Care Chiropractic, we offer a "no-pressure" environment, meaning we never pressure you into long-term contracts, instead we work with you in achieving your health goals. It's truly about you. We wish to extend you a warm welcome to Complete Care Chiropractic.

To get started, we need to get some details from you. We will start with a few basic questions outlined below. We will then get you to complete our intake form. Some questions may seem relevant, while others may seem unrelated. It is very important that you answer all of the questions completely and accurately.

Personal Details

Name: _____ Birthday: _____ / _____ / _____ Gender _____

Home Address: _____ City: _____ Postal Code: _____

Telephone (Home)_____ (Work)_____ (Mobile)_____

E-mail address:_____

Emergency Contact:_____ Relationship: _____ Phone: _____

Occupation: _____ Employer: _____

Medical Doctor: _____ Approximate last visit date: _____

How would you like to receive appointment reminders? ☐Text Reminders ☐Email ☐Home Phone ☐Work Phone

How did you hear of this practice? _____

PRIMARY COMPLAINT

Please indicate your primary complaint (ONLY PICK 1).

☐ Jaw Pain	☐ Low Back Pain	☐ Hand Pain	☐ Ankle Pain
☐ Headache	☐ Shoulder Pain	☐ Hip Pain	☐ Foot Pain
☐ Neck Pain	☐ Elbow Pain	☐ Thigh Pain	☐ Other: _____
☐ Mid Back Pain	☐ Forearm Pain	☐ Knee Pain	
☐ Rib Pain	☐ Wrist Pain	☐ Lower Leg/Shin pain	

Please answer the following questions regarding your primary complaint.

What side of the body is your pain on?	Left Side Right Side Both Sides Middle
When did it start? (exact as possible)	_____
What do you think caused it?	_____
How severe is the pain?	(min) 0 1 2 3 4 5 6 7 8 9 10 (max)
How often do you experience the pain?	< 25% of the time 25-50% 50-75% >75% of the time
Since the pain started, has it changed?	Getting Better Staying the Same Getting Worse
When is the pain at its worst?	Morning Afternoon Evening Nighttime No Difference
What makes the pain better?	Heat Ice Rest Movement Sitting Standing Walking Medications
What makes the pain worse?	Lifting Bending Coughing Sneezing Sitting Standing Walking Movement Rest
What does the pain feel like?	Sharp Stabing Dull Ache Throb Burning Numb Tingling Pins/Needles Other: _____
Does the pain refer to other areas?	Jaw Forehead Back of head Neck Mid Back Ribs Low Back Shoulder Elbow Forearm Wrist Hand Hip Thigh Knee Lower Leg Ankle Foot
Have you tried anything to help resolve it?	Chiropractic Physiotherapy Massage Family Doc Acupuncture Other: _____
Have you had this pain before?	☐ Yes ☐ No If yes, what helped the pain then? _____ If yes, does the pain feel similar? _____

MEDICAL HISTORY

1. Please list all current medications (including vitamins etc): _____

_____

2. Have you ever had any major car/work/sports accidents, broken bones, dislocations or any other injuries? _____

_____

3. Have you ever had any surgeries/hospitalizations? _____

_____

4. In the past 5 years, have you had any diagnostic tests (X-ray, MRI, CT, blood test, ultrasound etc): _____

_____

5. Have you ever experienced any of the following medical illnesses?

☐ HIV	☐ Hepatitis	☐ Stroke	☐ Heart Attack	☐ Hypertension	☐ Varicose Veins
☐ DVT	☐ Pacemaker	☐ Rheumatic Fever	☐ Pneumothorax	☐ Asthma	☐ Chronic Bronchitis
☐ COPD	☐ Emphysema	☐ Tuberculosis	☐ Epilepsy	☐ MS	☐ Depression
☐ Anxiety	☐ Polio	☐ Syphilis	☐ Meningitis	☐ Parkinson's	☐ Arthritis
☐ Cancer	☐ Osteoporosis	☐ Kidney Stones	☐ UTI	☐ Hemorrhoids	☐ Thyroid Disease
☐ Diabetes	☐ Anemia	☐ Allergies: _____		☐ Other condition: _____	

FAMILY HISTORY

7. Does anyone else in the family suffer from this condition: _____

6. Are you aware of any conditions/diseases/illnesses that run in the family: _____

SYSTEMS REVIEW

Are you currently experiencing any of the following?

General
- ☐ New mole
- ☐ Change in Mole
- ☐ Rashes
- ☐ Discolorations
- ☐ Bleeding
- ☐ Bruising
- ☐ Fatigue
- ☐ Muscle Aches
- ☐ Joint Pain
- ☐ Weakness
- ☐ Numbness
- ☐ Leg Cramps
- ☐ Leg Swelling

Gastrointestinal
- ☐ Heart Burn
- ☐ Bloating
- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Diarrhea
- ☐ Aggr. by food
- ☐ Aggr. by drinks

ENDO
- ☐ Excessive Thirst
- ☐ Altered Appetite
- ☐ Temp Intolerance

EENT
- ☐ Ringing in Ears
- ☐ Ear Pain
- ☐ Balance Issues
- ☐ Jaw Issues
- ☐ Sore throat
- ☐ Glasses/contacts

CSV/RESP
- ☐ Palpitation
- ☐ Cough
- ☐ Chest Pain
- ☐ Difficulty Breathing

NVS
- ☐ Mood changes
- ☐ Memory Loss
- ☐ Seizures
- ☐ Sleep Issues
- ☐ Tremors/Shakes
- ☐ Nervousness

URINARY
- ☐ Painful Urination
- ☐ Burning
- ☐ Discoloration
- ☐ Blood in Urine
- ☐ Incontinence

FEMALE ONLY
- ☐ Breast Lump
- ☐ Mid Cycle Bleed
- ☐ Irregular Periods
- ☐ Vaginal Discharge
- ☐ Vaginal Bleeding
- ☐ Pregnant
- ☐ Birth Control
- ☐ Hormone Therapy

MALE ONLY
- ☐ Bleeding
- ☐ Scrotal lump
- ☐ Scrotal swelling

RED FLAGS

Are you currently experiencing any of the following?

☐ Recent Infection	☐ Fever / Chills	☐ IV Drug Use	☐ Steroid Use	☐ Alcohol Use
☐ Osteoporosis	☐ Cancer	☐ Previous Cancer	☐ Weight Loss	☐ Night Pain
☐ Night Sweats	☐ Blood In Stools	☐ Altered Bowel Habits	☐ Altered Urination	☐ Recent Dizziness
☐ Recent Fainting	☐ Trouble Talking	☐ Trouble Swallowing	☐ Double Vision	☐ Numbness
☐ New Headache	☐ Altered Headache	☐ Vision changes	☐ Hearing changes	☐ change in taste
☐ Change in smell	☐ Cognitive changes	☐ Severe Headache that peaks in Seconds		☐ Abdominal Pain
☐ Heartbeat Sensation in Stomach		☐ Other: _____		

LIFESTYLE

Please indicate your typical daily work activities (example: desk work, occasional lifting, constant heavy lifting):

_____

_____

Alcohol & Cigarette Consumption

On average how many days per week do you drink alcohol: 0 1 2 3 4 5 6 7

On average how many alcoholic drinks will you have in one day: 0 1 2 3 4 5 6 > 7

How many cigarettes do you smoke per day: 0 1-3 4-6 7-9 10-12 13-15 16-19 > 20

What year did you start smoking: _____ What year did you quit smoking: _____

Exercise & Physical Activity

Do you dedicate specific time for exercise? Yes No

On average how many days per week do you do cardiovascular exercise: 0 1 2 3 4 5 6 7

On average how long will your cardiovascular exercise last (minutes)? < 10 15 30 45 60 >60

On average how many days per week do you strength train: 0 1 2 3 4 5 6 7

Attitudes & Beliefs

☐ I avoid most of my daily activities due to pain

☐ I usually rest until the pain is gone

☐ My mood is often affected by the pain

☐ I often worry that the pain will not get better

☐ I worry that movement will make the pain worse

☐ I often avoid socializing due to the pain

☐ I I often worry that the pain is due to something serious

☐ I believe that pain is harmful

HEALTH GOALS & EXPECTATIONS

What do you hope to achieve by consulting our office? Be as detailed as possible.

_____

_____

How long do you think it will take to reach your health goals?

_____

_____

How committed are you to reaching your goals?

☐ Not Very Committed ☐ Somewhat Committed ☐ Committed ☐ Very Committed ☐ Extremely Committed

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Intake Form Acknowledgement

I acknowledge and confirm that the above information is correct and true. I also provide my consent to allow the health practitioner to perform the exams/tests that he/she deems clinically relevant to come to a clinical impression and/or plan of management. **To be signed after consultation.

Sign:_____ (Patient/Guardian) Date: _____

Informed Consent to Osteopathic Care

Important Aspects to Note

Osteopathic mobilization is a low velocity, low amplitude movement. It involves applying a small slow force to a joint that results in gapping of that joint, and occasionally a popping sound.

Osteopathic care can help reduce pain in your neck, back, torso and other joints as well as provide relief from headaches and pregnancy related back pain. Osteopathic care can also help improve movement, flexibility, posture and gait, and can help to prevent muscle and joint injuries.

While rare, some patients may experience short term aggravation of symptoms or muscle/ligament sprains or strains as a result of manual therapy technique.

Although uncommon, rib fractures have known to occur following certain manual therapy procedures.

Although rare, there have been reported cases of disc injuries following cervical and lumbar spinal adjustment, however no scientific evidence has demonstrated that these injuries are caused by osteopathic treatment.

There are reported cases of stroke associated with visits to several healthcare providers. However research and scientific evidence does not establish a cause and effect relationship between manual therapy and stroke. Recent studies suggest that patients may be in the early stages of stroke while consulting with a health care professional. It is important to be aware that stroke may cause neurological impairment or even death, however the possibility of such injuries due to osteopathic treatment is extremely remote.

There are infrequent reported cases of burns or skin irritation in association with the use of some types of electrical therapy offered by some manual osteopaths.

Alternatives to Osteopathic Care.

There are other alternatives to osteopathic care including seeking medical advice, chiropractic care, massage therapy, physiotherapy, acupuncture etc. However, keep in mind all therapies have their own risks associated with them. You also have the option of doing nothing. Although the symptoms have a tendency to improve without treatment, this is not advised as there is an increased chance of re-occurrence in the future.

Consent

I acknowledge I have read this consent and I have discussed with my manual osteopath the nature and purpose of osteopathic treatment, the treatment options and recommendations for my condition, and the contents of this consent. I understand written consent is required before treatment, however can be withdrawn anytime. I consent to the osteopathic treatment recommended to me by my manual osteopath. I intend this consent to apply to all my present and future osteopathic care. **To be signed after consultation.

Date: _____

Print:_____ (Patient/Guardian) Sign:_____ (Patient/Guardian)

Print:_____ (Practitioner) Sign:_____ (Practitioner)

Office Policy

Here at the Complete Care we have developed a set of office policies to ensure that all of our patients receive the quality care that they deserve. Out of respect towards our staff and other patients, we ask that you do your best to follow these policies.

Accuracy of Information

I acknowledge and confirm that all the information provided by myself, to the clinic is in fact correct and true. This includes all the information contained within all forms of communication (written, verbal etc) with the clinic including but not limited to intake forms, consent forms, policy forms, EHC billing forms, and imaging request forms. By signing below you agree to this policy.

Privacy & Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or other third parties as deemed necessary for the management of my case. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission. By signing below you agree to this policy.

Cancellations & Missed Appointments

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 appointment, may be charged a cancellation fee. If appointments are repeatedly missed/cancelled, we will, regretfully have to dismiss the patient from care. By signing below you agree to this policy.

Health Education

We have found that when patients take an active role in their health they tend to experience better outcomes. This is why we offer additional health services including a monthly newsletter and blog service. It is our policy that our patients start receiving this service, however they can unsubscribe at any time. By signing below, you have agreed to this policy.

Payment Schedule

It is the responsibility of the patient/guardian to pay the balance on their account at the time the services are rendered. If insurance claims are being submitted on your behalf, you are responsible for any outstanding balance. Should you incur additional charges, the balance must be payed prior to commencement of care. If for any reason that it is necessary to discontinue your care, any outstanding fees will become due and payable immediately. By signing below you agree to this policy.

I have read and understand Complete Care Chiropractic's offices policies. I hereby agree with these policies & services. I understand that this document applies to all services that I choose to partake in at the clinic at this time and to any of the services I choose to receive at this clinic in the future.

Date: _____ / _____ / _____

Print:_____ (Patient/Guardian) Sign:_____ (Patient/Guardian)