New Patient Intake Form

ABLE BODY HEALTH CLINIC
www.ablebody.ca

Patient Information

Dr / Mr / Ms / Mrs / Mx _____ Sex: ❑ M ❑ F
(Family Name) (First Name & Middle Init.) (Preferred Name)

Address: _____
(Street Address) (City) (Postal Code)

Telephone Number: _____/_____/_____
(Home) (Work) (Cell)

Email: _____ (For appointment reminders, or requested updates; Will never be shared with any third parties)

Date of Birth: ____/____/_____ Age: _____ Marital Status: ❑ Single ❑ Married/Common-law ❑ Widowed
Day Month Year

Occupation: _____ Employer:_____

Emergency Contact: _____ Contact Number: _____

Alberta Health Number: _____

Medical Information

Family Medical Doctor's (MDs) Name: _____ Clinic: _____

Date of Last MD Visit:_____ Reason: _____

**Communication between health care providers (when needed) can greatly improve the quality of your care **
❑ I consent to allow my health provider at 'Able Body' to communicate with my medical doctor about my care
❑ I consent to allow my different health providers at Able Body to communicate about my care

Signature:_____

Have you ever received any of the following therapies before?

Therapy	City / Year	Therapy	City / Year
❑ Chiropractic		❑ Massage	
❑ Acupuncture		❑ Physiotherapy	

Extended Health Benefits and Other Insurance

Do you have a private Insurance plan? ❑ NO ❑ YES IF YES, What is the name of your plan (circle one):

AB Blue Cross / ASEBP / Great West Life / Chamber of Commerce / Green Shield / Manulife / Sun Life

Other: _____

Name of primary policy holder: _____ DOB of policy holder_____

Insurance Policy/Plan #: _____ Your ID/group #: _____

Is this a Workman's Compensation Case? ❑ NO ❑ YES Is this an automobile accident case? ❑ NO ❑ YES

How Did You Find Us?

❑ Referred by Medical Doctor ❑ Phone Book ❑ Internet/Website ❑ Street Sign ❑ Other
❑ Referred by Friend/Family (whom may we thank for this referral?_____)

I realize that my Insurance (Public or Private) may not cover 100% of the Doctors recognized fee schedule and that I am responsible for any difference between the Doctor's fee and the Insurance benefits.

Signature: _____ **Date:** _____

Signature of Parent or Guardian (if applicable): _____

Patient Symptoms/Complaint

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Name: _____ **Date:** _____

INSTRUCTIONS:

1) Please tell us the reason for your appointment: _____

2) When did this complaint begin? _____

3) Have you had a similar complaint before? ❑ NO ❑ YES If Yes, how long ago? _____

4) Have you received any tests or treatment for this complaint? ❑ NO ❑ YES If Yes, when?_____

5) Any recent accidents, injuries or surgeries? ❑ NO ❑ YES If Yes, Date: _____

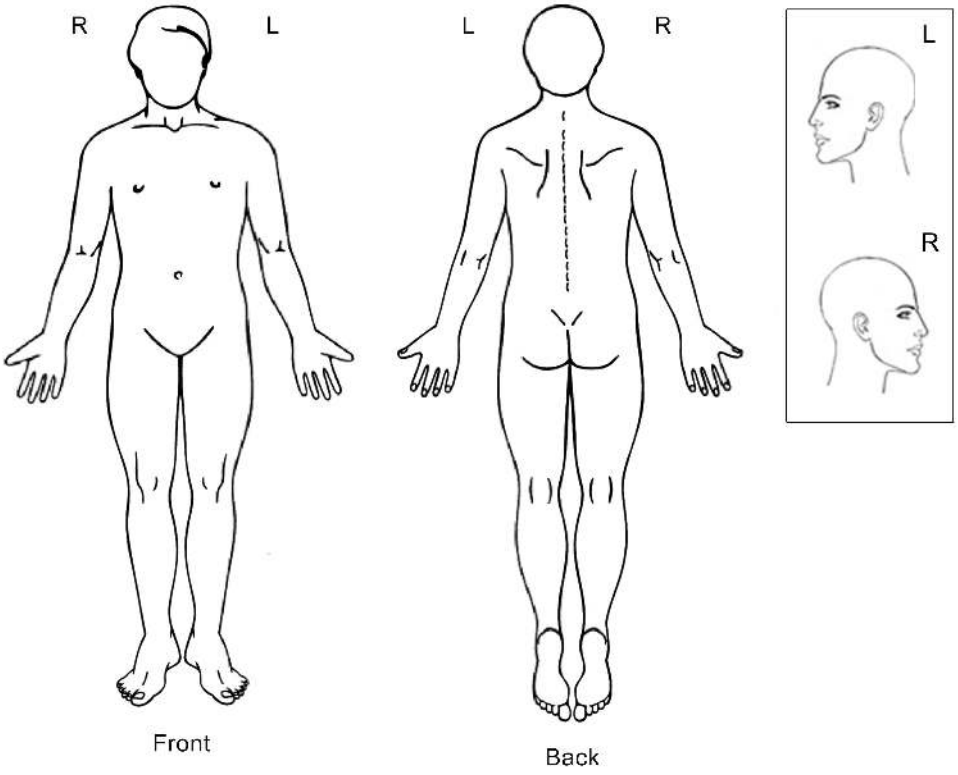
6) Please draw a face on the diagram of the person below.

7) Please indicate how severe your pain or discomfort is today by circling the most appropriate number below:

No Pain - 0 1 2 3 4 5 6 7 8 9 10 *- Worst Pain Possible*

8) Please use the symbols below to indicate what you are experiencing on the diagram of the person below:

Numbness	≡≡≡≡	Pins/Needles	~~~~	Burning	oooo
Sharp	xxxx	Dull/Achy	ΔΔΔΔ	Stiff/Tight	2222



Health Survey

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Name: _____ **Date:** _____

***Please check the box for any symptoms that you have had in the past 1 month:**

General Symptoms	Gastrointestinal	Skin
❑ Loss of consciousness	❑ Poor appetite	❑ Rashes or itching
❑ Headache	❑ Indigestion	❑ Bruise easily
❑ Fever	❑ Belching or gas	❑ Dry skin
❑ Excessive sweating	❑ Vomiting	❑ Hives (allergies)
❑ Night sweats	❑ Pain over stomach	**Cardiovascular**
❑ Weight loss/gain	❑ Diarrhea	❑ Chest pain
❑ Night pain	❑ Constipation	❑ Swelling around ankles
❑ Nervousness	**Eyes/Ears/Nose/Throat**	**Genitourinary**
❑ Loss of sleep	❑ Worsening vision	❑ Trouble urinating
Neurologic Symptoms	❑ Worsening hearing	❑ Blood in urine
❑ Dizziness	❑ Earache	❑ Incontinence
❑ Fainting	❑ Ears Ringing/Buzzing	❑ Prostate trouble
❑ Problems speaking	**Respiratory**	**GU for Women**
❑ Problems swallowing	❑ Chronic cough	❑ Painful menstruation
❑ Blurred or double vision	❑ Spitting up phlegm	❑ Hot flushes
❑ Nausea	❑ Spitting up blood	❑ Irregular/absent cycle
❑ Clumsiness	❑ Difficulty breathing	❑ Cramping/backache
❑ Numbness or tingling	❑ Pain with breathing	❑ Swollen/painful breasts

***Please check the box for any conditions you have ever been diagnosed with or told you have:**

❑ Cancer	❑ High Blood Pressure
❑ Thyroid disorder	❑ High Cholesterol
❑ Diabetes	❑ Previous Stroke or Heart Attack
❑ Anxiety / Depression	❑ Other (please specify)

Please list ALL medications or supplements that you are currently taking: _____

_____

Have you ever had a fracture or dislocation? ❑ No ❑ Yes; When? _____ Where? _____

Have you ever been hospitalized? ❑ No ❑ Yes; When? _____ Why? _____

Are you currently a smoker? ❑ No ❑ Yes - # packs/day: _____

Did you smoke previously? ❑ No ❑ Yes - # packs/day: _____ When did you quit? _____

WOMEN	- Are you currently using the birth control pill or patch? ❑ No ❑ Yes
	- Are you currently pregnant? ❑ No ❑ Yes
	- # of previous pregnancies _____ || # of children _____