Dr. Tahani Al-Rifai, HBSc, DC **Santosh Yadav, Physiotherapist**

148 Parkdale Ave. (Lower Level) N., Hamilton ON L8H 5X2 Phone: (289) 505-0824 Fax: (289) 621-3073

New Patient Intake Package

Please provide as much detail as possible, to ensure that the most comprehensive care can be offered.
All information is kept strictly confidential.

General Information

Name: ____ Date: ____ /____ /______

Gender: M / F Date of Birth: _DD___ /_MM___ /__YYYY___ Age: ______

Are you Pregnant? Yes No

Marital Status: married single divorced widowed Number of children: ___________

Address: _______________________________ City: _______________________ Prov: ______

Postal Code/Zip: ___________________ Email: ______________________________________

Home Phone#: ________________Cell Phone#: ________________ Work Phone#: _________________

Occupation: ________________________ Employer: ______________________

Do you receive health insurance benefits? Yes No

Who is your health insurance provider?____

Policy/Group No. _________________________ Certificate/Member ID _____________________

In Case of Emergency:

Emergency Contact Name: __________________________________Relationship: ___________________

Home Phone#: ________________ Cell Phone#: ________________ Work Phone#: _________________

Accident Information

Is this complaint related to a Motor Vehicle Accident? Yes No

Date of Accident: ____ /____ /______ Insurer's Name: ____

Claim #: _____________________ Insurer's Address/Phone: _________________________________

Is this complaint a WSIB Claim? Yes No

Date of Accident: ____ /____ /______ Employer Name: _______________________________________

Claim #: _____________________ Employer Address/Phone: ________________________________

If yes to any of the above, please give a **brief** description of the accident:

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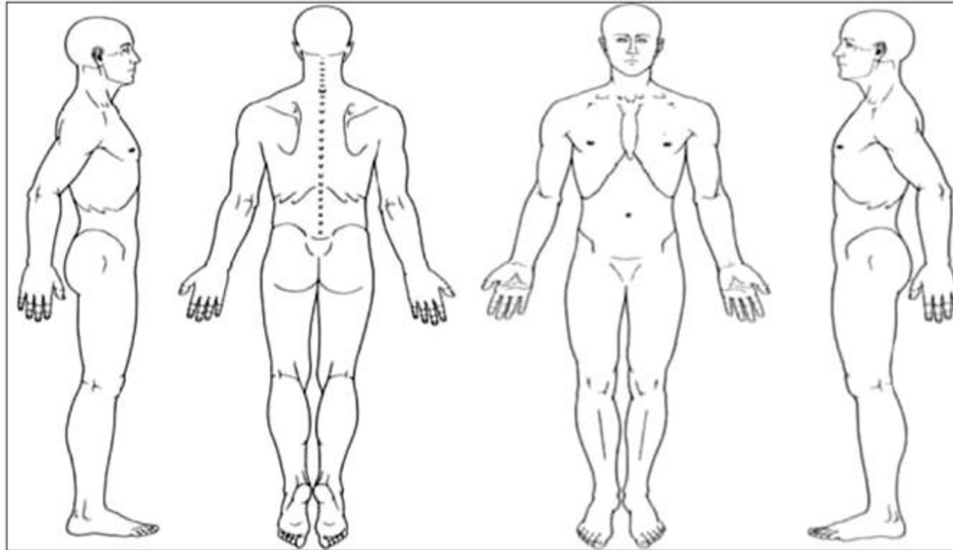
Current Patient Condition

Please mark the area of injury or discomfort on the chart below:



On a scale of 1 to 10, with 10 being the worst please indicate the severity of your pain:

No pain 0 ------ 1 ------ 2 ------ 3 ------ 4 ------ 5 ------ 6 ------ 7 ------ 8 ------ 9 ------ 10 Severe pain

Health History

Current Medications: Please list all medications (prescription, over-the counter, supplements)

Medication/Supplement	Dose (if known) & Length of Use	Prescribing Physician	Condition it is Treating

Please circle if you and/or your immediate family members (parents/ grandparents/siblings) have any of the following:

Myself:		**Family Members:**	
Cancer	Rheumatoid Arthritis	Cancer	Rheumatoid Arthritis
Stroke	Heart Disease	Stroke	Heart Disease
Hypertension	Diabetes	Hypertension	Diabetes
Epilepsy	High Cholesterol	Epilepsy	High Cholesterol

Do you smoke? Yes No If yes, how many per day? ____________ For how long? ________

Do you drink alcohol? Yes No If yes, how many per day/wk? _________

Use recreational drugs? Yes No If yes, what? _______________________How often? __________

List previous surgeries, traumas, accidents:

____

____

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Medical Conditions: Please indicate any serious illnesses, surgeries, fractures, motor vehicle accidents, sports injuries, hospitalizations, major childhood illnesses, allergies or trauma (physical, emotional, sexual)

Condition/Symptoms	C	P (date)	Condition/Symptoms	C	P (date)	Condition/Symptoms	C	P (date)
General Symptoms								
Fatigue			Night Sweats			Night Pain		
Chills/Fevers			Easy Sweating			Generalized Pain		
Fainting			Blackouts			Weight Loss		
Convulsions			Headache			Sleep Loss		
Neurological								
Dizziness			Difficulty Speaking			Difficulty Swallowing		
Blurred/Double Vision			Nausea			Loss of Coordination		
Loss of/Poor Memory			Numbness/Tingling			Involuntary Movement		
Musculoskeletal								
Joint Stiffness/Arthritis			Muscle Weakness			Muscle Spasm/Cramp		
Osteoporosis			Sciatica			Bursitis		
Bone Fractures			Artificial Joint			Easy Bruising/bleeding		
Respiratory								
Asthma/Wheezing			Chronic cough			Sputum/Mucous		
Shortness of Breath			Coughing up Blood			Tuberculosis		
Pain/Difficult Breathing			Bronchitis/Pneumonia			Emphysema		
Cardiovascular								
Heart Disease			High Cholesterol			High Blood Pressure		
Bleeding Disorder			Chest Pain/Angina			Stroke		
Poor Circulation			Varicose Veins			Swelling of Limbs		
EENT								
Vision Changes			Eye Pain/Discharge			Excess tears/dryness		
Glaucoma/Cataracts			Ringing/Buzzing Ears			Diminished hearing/aid		
Ear Pain/Infection			Frequent Colds			Sinus Infections		
Cold Sores			Thyroid Problems			Glandular Problems		
Gastrointestinal								
Poor Appetite			Indigestion			Excess Hunger		
Belching/Gas			Nausea/Vomiting			Stomach Pain		
Constipation/Diarrhea			Hemorrhoids			Liver disease/Jaundice		
Gall Bladder Problems			Ulcer			Diabetes		
Skin								
Rashes/Hives/Itching			Changes to moles			Eczema/Psoriasis		
Urinary/Sexual Health								
Pain/Burn w/ Urination			Blood in Urine			Kidney Problems		
Inability to Hold Urine			Frequent Urination			Urgency/Hesitancy		
Breast Lumps/Pain			Sexual Difficulties/Pain			STI		
Male Health								
Testicular Pain/Mass			Prostate Problems			Penile Discharge		
Female Health								
Painful Menstruation			Excessive Flow			Vaginal Discharge		
Irregular/Absent Cycle			PMS			Endometriosis		
Menopause			Ovarian Cysts			# Pregnancies/ # Kids		/

I attest that the above information provided is true and accurate to the best of my knowledge. I hereby authorize chiropractic/physiotherapy evaluation and care.

________________________________ _______________________

Signature Date

This is a confidential record of your medical history and will be kept at *Melvin Medical Clinic.* The information that it contains will NOT be released to anyone without your authorization.

BELLE CARE CLINIC

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Please Read and Sign:

I understand that Wellness and Rehabilitation Treatments (Chiropractic, Physiotherapy, Acupuncture, etc.) are not covered by OHIP and are my payment responsibility. The fees are reimbursed by most extended health insurance plans, WSIB and MVA insurance. I understand that professional fees are payable at time service is rendered. Insurance reimbursement is my responsibility as a patient and client. There are ***no refunds*** on custom-made or special order items including orthotics and footwear. If my insurance plan can be billed directly (electronically), I give the clinic permission to bill on my behalf. I am responsible for the difference or any funds not paid by my coverage plan. I realize that treatment rates may vary based on the following: type of treatment provided, workers compensation coverage and motor vehicle insurance coverage.

Our team aims to accommodate all patients with a scheduled treatment time that works within their daily routine. We strive to take on new patients and last minute emergency treatments into our schedule we always aim to stay on time with our appointments. Last minute cancellations (hours to minutes before a scheduled treatment) impact everyone concerned, including existing patient(s), practitioner(s) and new patients. Thus, we have created a **cancellation policy** in order to enforce t hat appointments are attended or cancelled/rescheduled at least 1 day (24 hours) prior. In the case of a missed or last minute cancellation the below fees apply. While we do not make courtesy reminder calls, it is ultimately your responsibility as a patient to attend appointments that you have booked.

Missed appointments for Chiropractic and Physiotherapy:
1st time: Friendly Reminder
2nd time: $25 missed or late cancelation fee.

I understand the above terms and conditions:

_______________________________________ _______________________________

Patient's Signature Date

Thank you ☺