New Patient Intake Form

ABLE BODY HEALTH CLINIC
www.ablebody.ca

Patient Information

Dr / Mr / Mrs / Ms _____ 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:_____

Name of Spouse/Partner: _____ Number of Children in Family:_____

Alberta Health Number: _____

Medical Information

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

Date of Last MD Visit:_____ Reason: _____

Communication between healthcare providers can greatly improve the quality and safety of your care. Do you consent to allow your health provider at 'Able Body' to contact your medical doctor about your health care?
❑ YES ❑ NO Signature:_____ Date:_____

Have you ever received any of the following therapies before?

Therapy	Name of Provider/Clinic	City & Year
❑ Chiropractic		
❑ Acupuncture		
❑ Massage		
❑ 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: _____

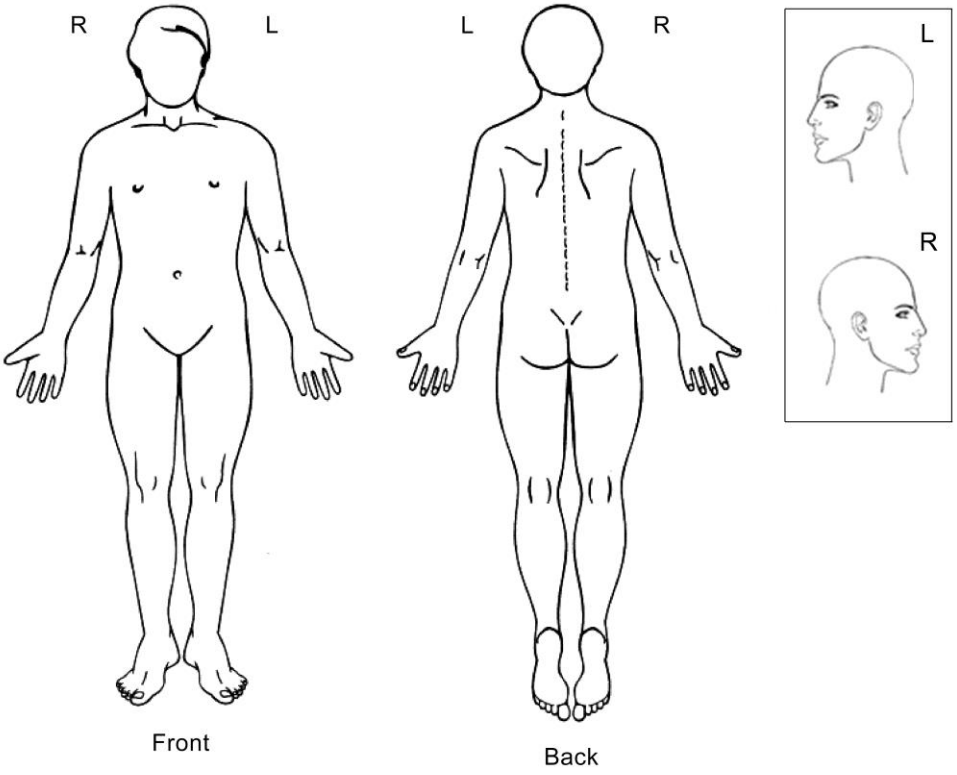
6) Please draw a face on the diagram below.

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 provided below to mark the pain or sensations you are experiencing.

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



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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**
❑ Convulsions	❑ Worsening vision	❑ Trouble urinating
❑ Loss of sleep	❑ Worsening hearing	❑ Blood in urine
Neurologic Symptoms	❑ Earache	❑ Incontinence
❑ Dizziness	❑ Ears Ringing/Buzzing	❑ Prostate trouble
❑ Fainting	❑ Frequent colds	**GU for Women**
❑ Problems speaking	**Respiratory**	❑ Painful menstruation
❑ Problems swallowing	❑ Chronic cough	❑ Hot flushes
❑ Blurred or double vision	❑ Spitting up phlegm	❑ Irregular/absent cycle
❑ Nausea	❑ Spitting up blood	❑ Cramping/backache
❑ Clumsiness	❑ Difficulty breathing	❑ Vaginal discharge
❑ 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 _____