Network Chiropractic Health Intake Form

SOURCE CENTRE
FOR HEALTH & WELLNESS

Practitioner: Dr. Leo Quan Date of Consultation:____________________

— Contact Information —

First Name:____________________ Last Name:____________________

Address:____

City + Prov:____________________ Postal Code: ____________

Best phone to reach you:____________ Cell/Home/Work *Can we leave a message?* Y ❍ N ❍

Second best phone:____________ Cell/Home/Work *Can we leave a message?* Y ❍ N ❍

Email:____

Would you like to be the first to get updates and special offers from our email newsletter? Y ❍ N ❍

Date of Birth (mm/dd/yyyy):_____/_____/_________ Gender:____________________

Relationship Status: Single ❍ Coupled ❍ Married/Common Law ❍ Divorced ❍ Widowed ❍

How many people live with you? ________ Adults _______ Children / Dependents

Occupation / Title:____________________ Current Employer:____________________

How did you find out about Source Centre or from whom?____________________

— Emergency and Medical Contact Information —

Your Physician's Name: ____________________ Phone: ____________

☐ I hereby give my consent to inform my family Doctor that I am under Network Chiropractic care.

Your signature____________________ Date____________

Your Emergency Contact's Name: ____________________ Phone: ____________

— Current Concerns —

What concerns do you have about your health and well being? Please list in order of importance.

____

____

— Regarding your MOST IMPORTANT concern —

In what part of your body do you experience your pain/symptoms?____________________

Does your pain/symptom travel to anywhere else in your body? Y ❍ N ❍

If Yes, where?____

What does this pain/symptom feel like? Please check any that apply:

Sharp ❍ Stabbing ❍ Dull ❍ Achy ❍ Numbness ❍ Tingling ❍ Burning ❍
Cold ❍ Pins & Needles ❍ Electricity ❍ Other (specify): ______________________________

When did this pain/symptom begin? ______________________________

What happened? ______________________________

How has the pain/symptom changed over time? Worse ❍ Better ❍ No Change ❍

How often does this pain/symptom occur? ______________________________

When your pain/symptom is present, how long does it last? ______________________________

MARK the level of symptoms you most consistently feel

What makes this pain/symptom better? ______________________________

What makes this pain/symptom worse? ______________________________

Are there any other related or associated concerns? ______________________________

Have you ever experienced this pain/symptom or something similar in the past? Y ❍ N ❍
If Yes, please describe ______________________________

Have you sought advice or treatment from a health professional? Y ❍ N ❍ If Yes, what were you told?

____

What was done? ______________________________ Did it seem to work? Y ❍ N ❍

— Medical and Chiropractic History —

Date and reason for last visit to medical doctor: (symptoms, diagnosis, treatment, outcome):

____

Please list any current medications / supplements that you are currently taking:

____

Please list any medications used in the past for more than three months and their purpose:

____

Have you or anyone in your extended biological family had any current or previous significant health issues? (i.e. heart disease/stroke, cancer, diabetes, infections) ? Please describe and indicate relationship.

____

Is there anything about your nervous system, spine or body that we should know about? Any concerns?

____

Have you been to a Chiropractor before? Y ❍ N ❍ If Yes, when, why did you go, what was done, what did you enjoy about your experience? ______________________________

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— Your History of Stress —

On a scale of 1 (Low) to 10 (High), please rate the following:

Current Life Stress ______ Level of Health ______ Overall Life Happiness _____

Mark PAST stressors with an UNDERLINE and stressors HAPPENING NOW with a CIRCLE

Traumatic Events

Slips Falls Car Accidents Injury Bone Fractures Surgeries Sprains Contact Sports

Repetitive Stressors

Lifting Bending Carrying Computer work Standing/Sitting for long periods Long drives

Chemical Stressors

Smoking 2nd Hand Smoke Vaccinations Medication Recreational Drugs Alcohol Caffeine
Refined Sugar Artificial Sweeteners Occupational Environmental Substance Abuse

Mental/Emotional Stressors

Relationships Family Children/Dependants Emotional/Sexual Abuse Divorce/Separation
Loss of Loved One Change in Residence Change in Career Work School Fast-paced Life
Internalized Feelings Quick Temper Perfectionist Procrastinator Financial Illness

Birth History

Home ❍ Hospital ❍ Forceps / Vacuum ❍ C-Section ❍ Other Trauma: ____________________

— Health and Lifestyle —

Please indicate any of these that apply to you.

Mark PAST involvement with an UNDERLINE and PARTICIPATION NOW with a CIRCLE

Chiropractic massage yoga pilates chelation homeopathy naturopathy acupuncture
ayurvedic medicine Qi Gong Tai Chi meditation art / music therapy herbalist psychotherapy
rebirthing breathwork movement therapy body talk energy work nutritional therapy osteopathy
prayer place of worship cranial work herbs supplements reiki

When stressed, how do you "centre" yourself or "re-group"? ____

Is there some aspect of your life that very much pleases you, brings you joy or helps you to feel good?

____

How many hours of sleep do you get? _____ What is the quality? Low ❍ Med ❍ High ❍

Please rate your:	**Great**	**OK**	**Dissatisfied**
Ability to Fall Asleep	❍	❍	❍
Ability to Stay Asleep	❍	❍	❍
Vitality, Energy	❍	❍	❍
Alertness, Clarity	❍	❍	❍

Yesterday, what did you choose to eat for Breakfast? ____________________

Lunch? ____________________ Snack? ____________________

Dinner? ____________________ What is your daily fluid intake? ____________________

Please rate your:	**Great**	**OK**	**Dissatisfied**
Mental Focus and Concentration	❍	❍	❍
Weight and Body Image	❍	❍	❍
Digestive Function	❍	❍	❍
Bowel Movement and Urination	❍	❍	❍

How much or what kind of physical activity do you get? ____________________

Are you training? Y ❍ N ❍ If Yes, please explain ____________________

What type of work do you do, activities and responsibilities ____________________

____

Please rate your:	**Great**	**OK**	**Dissatisfied**
Balance, Coordination	❍	❍	❍
Flexibility, Endurance, Strength	❍	❍	❍

What do you do for play and relaxation? ____________________

When was your last vacation? ____________________

Please rate your:	**Great**	**OK**	**Dissatisfied**
Time for Self	❍	❍	❍
Work and Career	❍	❍	❍
Financial Situation	❍	❍	❍
Connectedness with Others	❍	❍	❍
Intimate Relationship(s)	❍	❍	❍

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— Your Health Goals with Network Chiropractic —

❍ Heal disease, symptoms and illness
❍ Prevent disease, symptoms and illness
❍ Improve family and/or community health
❍ Maximize personal health potential

In a peer-reviewed and published study of over 2,800 participants under Network Chiropractic care, the participants reported an overall improvement in several categories of health and wellness listed below.

My Goals are:	**Definitely**	**Would be Nice**	**Unimportant**
Improve physical symptoms	❍	❍	❍
Improve emotional/mental symptoms	❍	❍	❍
Improve my ability to react/respond to stress	❍	❍	❍
Improve ability to make constructive choices	❍	❍	❍
Overall improved quality of life	❍	❍	❍

What is your commitment to yourself, your life and well-being on a scale of 1 to 10, where 1 is no commitment and 10 is "will do whatever it takes"? __________

Are there factors or elements about your life, that may *impair* your opportunity for full vitality and health?

____

Are there any factors and elements that could give you an *edge* or add to your health?

____

Is there anything else that may help in understanding you, your history or your professional needs which have not been discussed on this survey? ______________________________________

____

____

Thank you for completing this form and for choosing Source Centre

SOURCE CENTRE GENERAL POLICIES

On your first visit, it is required that you fill out health history forms which should be updated yearly with any address or health changes that your practitioner should be aware of. Your practitioner will review this information with you and ask questions to ensure that you receive the treatment that meets your needs. Ongoing progress reports will be attached to your file on a regular basis.

Cancellation/Missed Appointment Policy

If you are unable to make an appointment, we request that you call 24 hours in advance. If you do not call to cancel or if you do not show up for your appointment, a cancellation fee will be charged. The fee for cancellations is equal to 50% the normal rate. If you book within the 24hr time frame, this policy becomes effective immediately. ***All cancellation fees are subject to HST.*

Lateness Policy

Your appointment reserves the specified time for your visit (60 minutes, 90 minutes etc.). If you arrive late for your appointment, you will be charged the full amount of your booked appointment but only receive treatment equal to the time remaining.

Cell Phones/Pagers within the Centre

Please understand that to achieve an environment of quiet and relaxation we ask that you turn off your cell phone, pager or other electronic devices.

Email Etiquette and Consent

We strive to keep in touch with our clients by all media available, the most common of which being Email. We ask that you keep the following in mind when using email to communicate with us:

1. E-mail is not appropriate for urgent or emergency problems, including last minute cancellations.
2. E-mail is not confidential. Employers have a legal right to monitor e-mail if they choose; system operators for most e-mail systems have access to all e-mail that passes through their systems.
3. E-mail communications travel across the public Internet. It is not always possible to verify that e-mail is actually received, opened and read by the addressee. If you do not receive a response, do not assume that we have actually received the message.
4. There is no way to assure the privacy of e-mail on a shared computer or e-mail account.
5. All e-mail correspondence will become a part of your medical record at the clinic.
6. It is extremely important to include your name and the name of your practitioner on every e-mail sent to the Source Centre.

By signing this document, you are confirming that you have read and understood the above information about the use of email to communicate matters pertaining to your health and healthcare, and understand the issues inherent in this use.

Consent to Terms of Services (Summary)

Providing you with the highest level of service is our business and we take this very seriously. Please take a minute to review our Terms of Services on our website so you are aware of what you may expect from us. In order for us to ensure you receive the highest level of care, we ask that you respect these Terms. http://www.sourcecentre.ca/about/more/terms-service/

Privacy Policy Consent

As of January 1st, 2004, the Canadian Federal Government's Personal Information Protection and electronic Document Act (PIPEDA), was created. This privacy law requires your knowledge and consent before we may collect your personal information, except in rare circumstances. This means we want you to understand what we do with personal information we obtain about you. Our full Privacy Policy is available at your request and is posted on our web site at http://www.sourcecentre.ca/about/more/privacy/

Collection of Personal Information (Summary)

In order to provide you a health service we must collect some personal information, including but not limited to: telephone number, address, occupation, health history, prescriptions, involvement in other healthcare, etc. This information will be kept strictly confidential and will not be disclosed to any third party with the exception of the following: with your direct written consent, a medical emergency while you are on the premises, when required by law (i.e. court subpoena) or during regulated healthcare assessment purposes for quality assurances.

Please review our full Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and your right to review your personal information. If you have any questions or concerns about the Privacy Policy, it is your responsibility to address them immediately with your practitioner.

Sharing of Personal Health Information with other Source Centre Practitioners

I consent to Source Centre practitioners, whose care I am under, sharing personal health information amongst themselves with regards to my care, for the purpose of enhanced clinical outcomes Y ❍ N ❍

By signing this Source Centre General Policy form, you are indicating that you have read and consented to all of these policies and that you have had a chance to read, and agree to, our Privacy Policy and our Terms of Service. If there is anything you do not understand in any of the above, please talk to us immediately.

I agree that I have read and understood all the policies, and I have been given a chance to ask any questions I have about the Privacy Policy and Terms of Services and that they have been answered to my satisfaction.

Signature ____

Client Name ______________________________________ Date_______________________

Signature of parent or Guardian (for anyone under the age of 18):

Signature ____

Guardian/Parent Name ______________________________ Date_______________________