# Active-Med Health and Wellness Centre

**Welcome to Active-Med Health and Wellness Centre!**

**In order to serve you better, please take a moment to complete this form.**

## Patient Information

Last Name: ____________________________ First Name: ________________________ Initial: __________ Today's Date: ___ /___ / ______
Date of Birth: (MM/DD/YYYY) ___ / ___/ ______ Gender: M/F Current Weight: _____ Ideal Weight: ______
Address: ________________________________________________ City: _____________ Province: _________ Postal Code: ________
Telephone Number: (home): _______________ (work): ______________ (mobile): _______________ Email: __________________________
May we leave you phone messages/call/email to confirm and cancel appointments? Yes/No
Marital Status: Single/Married/Separated/Divorced/Widowed # of Dependents _____ # of Dependents under 18 _____ Occupation: __________
How did you learn about us? (if referred, please name the referral): ____________________________________________________________

**Emergency Contact Information:**
Name: ________________________________________________Relationship: __________________ Phone Number: ________________

**Other Health Care Providers:**
Name of family doctor: ______________________________ Address: _______________________________Phone: ___________________
Name of specialists/doctors: __________________________ Address: _______________________________Phone: ___________________
Last physical exam (MM/YY): __________ Last blood work: (MM/YY): __________

## Case Information

What is your primary complaint? ______________________________________________________________________________
Do you require treatment as a result of an accident? ◯Yes ◯No Description of the Accident:
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

◯ Automobile Accident
Automobile Insurance Company: __________________________ Policy #: ___________ Claim #: ___________ D.O.A: _________
Adjuster Name: __________________________________________ Tel: ______________________ Fax: ____________________
Have you already reported your injuries to the insurance company? ◯Yes ◯No
Were you employed at the time of the accident? ◯Yes ◯No
Are you receiving any disability coverage? ◯Yes ◯No
Do you have a legal representative? ◯Yes ◯No
Name of Company: ________________________ Representative Name: _________________Phone Number: ________________

◯ Extended Health Care
Name of Company: ________________________ Policy/Group#: _________________ Certificate/Member ID:________________
Policy Holder same as patient? ◯Yes ◯No Last Name: _______________ First Name: _______________ D.O.B: ___________
Name of Company: ________________________ Policy/Group#: _________________ Certificate/Member ID:________________

◯ Work Injury D.O.A: ___________ Claim #: ___________ Nurse Case Manager: ____________________ Tel: ____________________
WSIB Adjuster: __________________________________________ Tel: ______________________ Fax: ____________________

◯ Slip and Fall Date of Accident: ___________
Do you have a legal representative? ◯Yes ◯No
Name of Company: ________________________ Representative Name: _________________Phone Number: ________________

**Please present the following documents:**

◯ Drivers License ◯ Health Card ◯ Police Report ◯ Insurance Pink Slip ◯ Extended Health Benefits Card

**Please note that 24HR Appointment cancellation notice is required to avoid charges.**

# Active-Med Health and Wellness Centre

**General Information:**

For the following questions please include amount, type, frequency, and duration of use.

- Do you Smoke: Yes ◯ No ◯ Comments: ____________________
- Are you exposed to Second Hand Smoke: Yes ◯ No ◯ Comments: ____________________
- Do you use Recreational Drugs: Yes ◯ No ◯ Comments: ____________________
- Do you drink Alcohol: Yes ◯ No ◯ Comments: ____________________
- Have you used Steroids or Cortisone: Yes ◯ No ◯ Comments: ____________________
- Do you use Antacids: Yes ◯ No ◯ Comments: ____________________
- Do you use Laxatives: Yes ◯ No ◯ Comments: ____________________
- Do you drink Coffee/Tea: Yes ◯ No ◯ Comments: ____________________
- Do you Exercise: Yes ◯ No ◯ Comments: ____________________
- Are you frequently exposed to animals: Yes ◯ No ◯ Comments: ____________________
- How many hours of Sleep do you get: ____________ Solid _____ Interrupted _____ Comments: ____________
- Do you feel refreshed in the morning: Yes ◯ No ◯ Comments: ____________________
- Do you do Shift Work: Yes ◯ No ◯ Comments: ____________________
- Do you use a computer? Yes ◯ No ◯ How many hours per day? ________ Comments: ____________
- How would you describe your general state of health?
  Excellent ◯ Good ◯ Fair ◯ Poor ◯ Comments: ____________________
- What level of Stress are you experiencing right now?
  Minimal ◯ Average ◯ Considerable ◯ Unbearable ◯
- The main stressor is: Financial ◯ Interpersonal ◯ Job Related ◯ Marriage ◯ Family ◯ Health ◯
- Unfulfilled Expectations ◯ Spiritual ◯ Other: ◯ ____________________
- How is your Energy level: Excellent ◯ Good ◯ Fair ◯ Poor ◯

**Family History:**

Please indicate which of your close relatives has or had any of the following:

Heart Disease: ◯ High Cholesterol: ◯ Arthritis: ◯ Diabetes: ◯ _________ Blood Pressure: ◯ ________
Thyroid Problem: ◯ Asthma: ◯ Kidney Disease: ◯ Depression: ◯ Other Mental Health Illness: ◯ _________
Cancer: ◯ Epilepsy: ◯ Allergies: ◯ Alcoholism: ◯ Drug Abuse: ◯ Hemophilia: ◯ Other:
____________________________________________

**Medical History:**

Please indicate all conditions you have experienced. Mark C for Current or P for Past.

**General Symptoms**

__ Fainting
__ Dizziness
__ Loss of Sleep
__ Fatigue
__ Nervousness
__Sudden Weight Loss/Gain
__ Numbness
__ Tingling
__ Paralysis
__ Headaches (Tension)
__ Migraines
__ Depression

**Infectious**

__ Hepatitis: _______
__ Tuberculosis
__ HIV
__ Herpes
__Cold
__ Flu
__ Athlete's Foot
__ Warts

**Cardiovascular**

__ High Blood Pressure
__ Low Blood Pressure
__ Coronary Heart Disease
__ Heart Attack
__ Phlebitis
__ Stroke/CVA
__ Pacemaker
__ Heart Murmur
__ Palpitations
__ Varicose Veins
__ Swelling of the Ankles
__ Poor Circulation

**Digestive**

__ Poor Appetite
__ Belching/Gas
__ Constipation
__ Diarrhea
__ Nausea
__ Ulcer
__ Vomiting

**Skin**

__ Rashes
__ Itching
__ Bruise Easily
__ Dryness
__ Boils
__ Other: ________

**Other Medical Conditions**

__ Anemia
__ Epilepsy
__ Cancer: _______
__ Multiple Sclerosis
__ Diabetes: ______
__ Mental Illness: __________
__ Gout
__ Kidney Disease
__ Thyroid Disease: _______
__ Eczema
__ Pins
__ Wires
__ Artificial Joints
__ Rods

**Eye, Ear, Nose, Throat, Respiratory**

__ Allergies
__ Frequent Colds
__ Glasses or Contacts
__ Hearing Aid
__ Hearing Loss
__ Sinus Infection
__ Swollen Glands
__ Chronic Cough
__ Bronchitis
__ Asthma
__ Hay Fever
__ Difficulty Breathing
__ Emphysema
__ Pneumonia

# Active-Med Health and Wellness Centre

Please list your Health Concerns/Goals by the order of importance:
1. ___
2. ___
3. ___
4. ___
5. ___

Please indicate any traumatic event (surgery, trauma, accident), illnesses, injuries and hospitalization along with approximate dates:
___
___

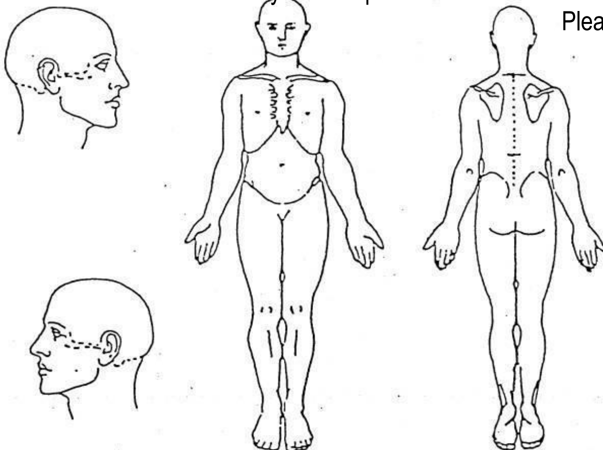
Please list all current medications/supplements: (prescription, over-the-counter, vitamins, minerals, herbs, homeopathics, etc.)

| Medication | Date started | Dose/frequency | Purpose |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

In the last five years, how many courses of antibiotics have you taken: ___
When was the most recent course of antibiotics: ___

## Pain:

Please mark the areas where you have pain:



Please indicate all conditions you have experienced. Mark C for Current or P for Past.

### Joint/Soft Tissue Discomfort

__ Arms
__ Neck
__ Shoulder
__ Upper Back
__ Mid Back
__ Lower Back
__ Degenerative Discs
__ Feet
__ Hands
__ Jaw
__ Knees
__ Legs
__ Osteo Arthritis
__ Rheumatoid Arthritis
__ Sciatica
__ Limitation of Movements: (in which joints): ___
__ Other: ___

***Female Patients Only:***
Are you currently pregnant? Yes ___ No ___ if Yes, how many weeks: ___ Due Date: ___
Are you Breastfeeding: Yes ___ No ___ Are you trying to conceive: Yes ___ No ___ Are you taking birth control pills: Yes ___ No ___
When was your last Pap Smear test: ___ Date of your last menstrual period: ___
__ Heavy Flow __ Pre-menopausal
__ Irregular Cycle __ Menopausal
__ Swollen Breasts

# Active-Med Health and Wellness Centre

**PRICE LIST:**

| Service | Initial | Subsequent | Motor Vehicle Accident |
|---|---|---|---|
| Chiropractic | $120 | $60 (Rehab)<br>*may differ depending on modalities needed. | $112.81 |
| Physiotherapy | $120 | $70-$120<br>*Price depends on modalities needed. | $99.75 |
| IFC Pads | $7.00 | | $7.00 |
| Massage Therapy<br>** please inquire about specialty massage prices (Thai/Reflexology/Sports massages) | | $150+tax (90min)<br>$95+tax (60min)<br>$80+tax (45min)<br>$60+tax (30min) | $58.19+tax (30min) |
| Naturopath | $160 | $160 (60min)<br>$120 (45min)<br>$80 30min) | $160 (60min)<br>$120 (45min)<br>$80 30min) |
| Acupuncture/Cupping | $90 | $75 (30min)<br>$90 (45min) | $58.19 (30min) |
| Holistic Medicine/Nutritional Counseling<br>All supplement charges are separate. | $90<br>*Please inquire* | $90<br>$60 (30min)<br>*Please inquire* | $58.19 (30min)<br>*Please inquire* |
| Custom Orthotics (includes casting, gait analysis, custom orthotics, and fitting) | $450 | ----- | $450 |
| Compression Stockings (includes measurements, 2 compression stockings, and fitting) | Please inquire | ----- | Please inquire |
| Orthopedic Devices | Please inquire | ----- | Please inquire |
| Assessments | $215.00 | $200.00 | $215.00 |
| Progress Letters | from $75.00 | ----- | $350.00 |
| Sick Notes | $30.00 | ----- | ----- |
| Copy of File | From $75.00 | ----- | From $125.00 |
| No Show/Short Notice Cancellations | $40.00 | ----- | Full provider fee |

Please inquire for the prices for all of the other services we provide at this facility.

All prices are subject to change without notice.

*I affirm that I have stated all my known medical conditions and answered all questions honestly. I understand that I am responsible for any charges incurred in the course of my treatment including cancellation charges if I fail to give a 24hour notice. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.*

Patient Name: ______________________________ Signature: ______________________________________ Date: ________________