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
10650 Leslie St Unit 7 Richmond Hill ON L4S 0B9 T:905.237.2012 F:905.237.2013 www.active-MED.ca info@active-MED.ca

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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

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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.)

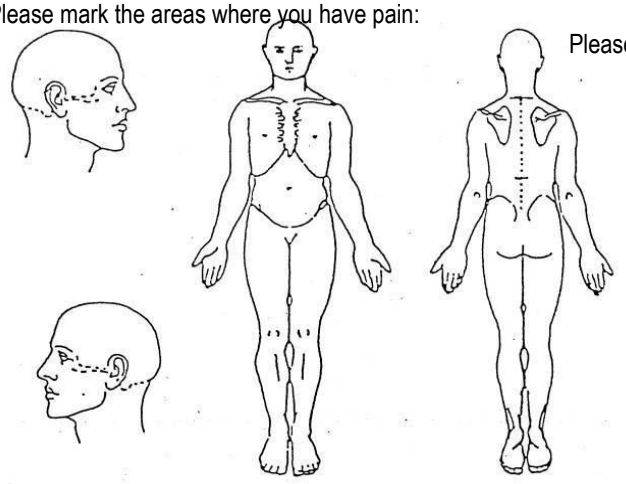
Medication	Date started	Dose/frequency	Purpose

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

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PRICE LIST:

Service	Initial	Subsequent	Motor Vehicle Accident
Chiropractic	$90	$60 (Rehab) *may differ depending on modalities needed.	$112.81
Physiotherapy	$120	$120 (60min) $90 (45min) $70 (30min)	$99.75
Massage Therapy ** please inquire about specialty massage prices (Thai/Reflexology/Sports massages)	$90+tax (60min)	$140+tax (90min) $90+tax (60min) $70+tax (45min) $50+tax (30min)	$58.19 (30min)
Naturopath	$160	$160 (60min) $120 (45min) $80 30min)	$160 (60min) $120 (45min) $80 30min)
Acupuncture/Cupping	$90	$60 (30min)	$58.19 (30min)
Holistic Medicine/Nutritional Counseling All supplement charges are separate.	$90 *Please inquire*	$90 $60 (30min) *Please inquire*	$58.19 (30min) *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	-----	$40.00

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 sh ould I fail to do so.

Patient Name: _____ Signature: _____ Date: _____

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