CORNERSTONE
THERAPY & WELLNESS

PATIENT INTAKE FORM

By completing this form, you acknowledge that you understand that 24 hours is required to cancel any appointments, otherwise you will be charged a late cancellation/no-show fee.

Patient Name: ____ Birth Date (D/M/Y):____/___/______

Email *(for appointment reminders & paperless receipts):* ____

Address: ________________________________ City:_______________________ Postal code:___________

Phone (Home):____________________________ Phone (Cell):___________________________________

Occupation: _____________________ How did you hear about our clinic? ___________________________

Emergency Contact _____________________ Phone: ________________ Relationship: _______________

GUARDIAN (Please complete if under 16 years of age):

Name: ____ Birth Date (D/M/Y):____/____/__________

Guardian Signature: __________________ ______________________ Date: ______________________

PRIMARY CARE PHYSICIAN:

Physician name: ______________________________________ Phone: ___________________________

Address: ____

FEE SCHEDULE:

Chiropractic:

Initial Exam:	$90.00
Non-Complex Treatment:	$45.00
Complex Treatment:	$55.00
Laser Therapy:	$55.00
Spinal Decompression	$70.00

Physiotherapy:

Initial Exam:	$90.00
Treatment:	$70.00
Complex Treatment:	$90.00
New Injury Assessment:	$90.00

Massage/Athletic Therapy/Personal Training:

30-minutes:	$65.00
45-minutes:	$80.00
60-minutes:	$95.00
90-minutes:	$135.00

Other Services:

Custom Orthotics:	$400.00

All prices include tax (where applicable)

Services provided are not covered by OHIP

CORNERSTONE THERAPY & WELLNESS

CONSENT TO CHIROPRACTIC EXAMINATION:

The risks associated with a chiropractic examination include, but are not limited to, short term aggravation of symptoms or muscle and ligament strains or sprains, and disc injuries. Although rare, rib fractures have been known to occur. The most common reactions to a chiropractic examination, if any, are muscle soreness and/or an increase in symptoms.

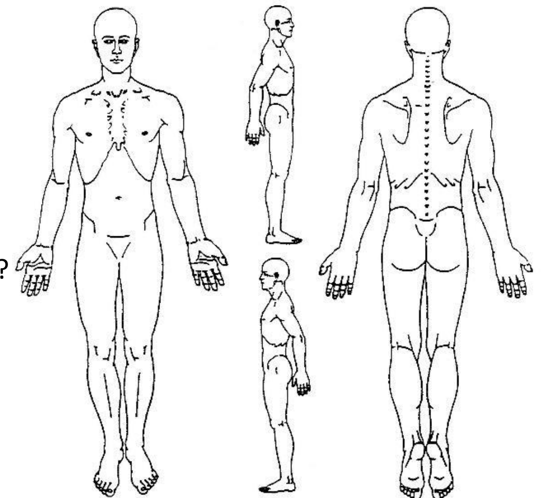
If you are not comfortable, you may stop the examination at any time. Please be involved in and responsible for your care. Inform your chiropractor immediately of any change in your condition. I hereby consent to the chiropractic examination.

Print Patient Name:____

Signature:________________________________ Date (D/M/Y) _______/_______/____________

Chiropractor Signature:______________________________________ Date (D/M/Y) _______/_______/____________

Please mark below where the pain is located



ADDRESSING WHAT BROUGHT YOU TO THE CLINIC:

1. What is your main symptom/problem? __________________________
2. When did your symptoms begin? _______________________________
3. Have you had this problem before? ☐Yes ☐No
4. Is the problem there – ☐constantly ☐comes & goes ☐with use ☐at rest?
5. Is the problem getting - ☐worse ☐no change ☐better?
6. What makes it worse? _____________________________________
7. What makes it better? _____________________________________
8. How does it feel? ☐Burning ☐Sharp ☐Shooting ☐Dull ☐Stiff ☐Aching ☐Tingling ☐Throbbing

☐Swelling ☐Other:______________________

9. How would you rate the severity of your pain (0 = no pain, 10 = severe pain)? ________
10. Does it interfere with your: ☐Work ☐Sleep ☐Daily Routine ☐Recreation?
11. What tests have you had for this condition?: ☐Ultrasound ☐X – Ray ☐MRI ☐CT Scan
12. Have you received any treatment for this condition? ☐Chiropractic ☐Physiotherapy ☐Massage Therapy

☐Acupuncture ☐Surgery (Date D/M/Y: _______________) ☐Other: __________________________

PATIENT HEALTH QUESTIONNAIRE:

Please check if any of the following apply to you. Knowledge of these conditions may influence the type of treatment you receive.

☐Anxiety/depression
☐Arthritis
☐Asthma
☐Cancer
☐Chest Pain
☐Chronic fatigue
☐Cold hands/feet
☐Diabetes
☐Digestive problems

☐Dizziness/Vertigo
☐Epilepsy
☐Falls/Head injuries
☐Headaches
☐Heart Disease/Attack
☐Herniated Disc
☐High Blood Pressure
☐Jaw Pain/TMJ
☐Pacemaker

☐Osteoporosis
☐Pain –Neck
☐Pain – Mid Back
☐Pain- Arm/Elbow
☐Pain – Hand
☐Pain – Wrist
☐Pain – Shoulder
☐Pain – Ankle or Foot
☐Pain – Leg

☐Pain – Knee
☐Allergy
☐Scoliosis
☐Stroke
☐Swelling, Stiffness of Joints
☐Tinnitus (Ear Noises)
☐Hearing, Vision loss
☐Other_____________

Medications/supplements you currently take :____

Allergies: ____

Are you pregnant?: ☐No ☐Yes How many weeks? ___________

HAVE YOU EVER:

Had an accident (car, fall, sport, other)? ☐No ☐Yes, please describe: ____

Had an operation? ☐No ☐Yes, please describe: ____

Had a fracture? ☐No ☐Yes, please describe: ____

Been hospitalized? ☐No ☐Yes, please describe: ____

FAMILY HISTORY: Have your grandparents, parents or siblings ever been diagnosed with any of the following?

□ High Blood Pressure
□ Heart Attack
□ Stroke
□ Diabetes (Type I or Type II)
□ Thyroid/ Hormone Problems
□ Breathing or lung problem

□ Rheumatoid Arthritis
□ Osteoarthritis
□ Neurological problems
□ Cancer
□ Kidney Disease
□ Other specify: ______________________

I certify that all the above personal health information, on page one and two, is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition in the future.
Print Patient Name:____

Signature:_________________________________ Date (D/M/Y) _______/_______/____________

All Information provided is confidential

Informed Consent

I hereby request and consent to the assessment and treatment procedures at Cornerstone Therapy and Wellness, including various modes of Chiropractic Treatments provided by my Chiropractor and/or those working in this clinic authorized by those staff.

I will have an opportunity to discuss with my Chiropractor the nature and purpose of the treatment procedure(s). I am aware that modalities such as cold laser therapy, motorized spinal decompression, IFC, and ultrasound as well as therapeutic tools such as acupuncture, may be used as part of my treatment at the discretion of my Chiropractor and I consent to the use of these tools once he has explained the nature of them. I acknowledge that no assurance or guarantee is provided to me as to the results of the treatment.

I acknowledge and understand that my Chiropractor must be fully aware of my existing medical conditions. I have completed my medical history form as provided by the professional staff and disclosed all medical conditions affecting me. It is my responsibility to disclose any allergies before my treatment begins, or to let my Chiropractor know if I feel as though I may be having an allergic reaction to the products being used at the time of treatment. It is my responsibility to keep my Chiropractor updated on any changes to my medical condition. The information I have provided within my completed medical history is true and complete to the best of my knowledge. I understand that I am encouraged to communicate with my Chiropractor about any aspect of my treatment.

As with any type of treatment, although rare, there are risks associated with Chiropractic treatment. These risks include, but are not limited to, short term aggravation of symptoms, muscle and ligament strains or sprains, disc injuries, skin irritation, rib fractures, and strokes, have all been known to occur. I do not expect my Chiropractor to be able to anticipate and/or explain all the risks and complications.

Our Chiropractors respect your right to modify, refuse or terminate your consent at any time, regardless of prior consent given. Cornerstone Therapy & Wellness respects the confidentiality of all patient information unless disclosure is required by law or by court order. I understand that my information will not be released otherwise, unless my written consent is given.

I have read the above noted consent and understand that I will have the opportunity to question the consent and my treatment. By signing this form, I agree to the above named procedures. I intend this consent form to cover the entire course of my treatment for my present condition and for any future condition(s) for which I seek treatment at this clinic.

_______________________________________ ___________________________________ Date: ____________ ____
Name (Please Print) Signature

_______________________________________ Date: ________________.
Chiropractor Signature

CORNERSTONE THERAPY & WELLNESS
574 Carlton Street
St. Catharines, ON L2M 4X9
(905) 934 - 2121

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INFORMED CONSENT FOR ACUPUNCTURE TREATMENT

I hereby agree and consent to the performance of acupuncture. Acupuncture is a technique utilizing fine stainless steel needles inserted at specific points in the body to correct various ailments.

Occasionally there may be increased soreness at the sites of treatment on the day of, or day following treatment. I have been informed that in all acupuncture treatments only sterile, disposable needles are used to ensure the safest acupuncture treatment possible.

I have been informed that acupuncture is a safe method of treatment, but may have some side effects, including bruising, numbness or tingling, dizziness or fainting, minor swelling, bleeding, hematoma may occur at the site of insertion and may last a few days. A sensation of lightheadedness may occur after acupuncture treatment. I will immediately notify the practitioner if I experience any symptoms or problems.

I understand that I should not make significant movements while the needles are being inserted, manipulated, retained, or removed. I am relying on the practitioner to exercise judgment during the course of my treatment, trusting that this treatment plan is appropriate and in my best interests.

At any given time throughout the treatment, I may request the practitioner to stop, modify or change the treatment plan. I state that I do not have the following conditions: pregnancy, bleeding disorders, pacemaker, local infections; or am currently taking anticoagulants.

By voluntarily signing below I hereby certify that I have read this entire form, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions and that I consent to treatment with the modalities described above. I intend this consent form to cover the entire course of treatment to be performed for my present condition and for any future condition(s) for which I seek treatment.

_______________________________________ ___________________________________ Date: ____________ ____
Name (Please Print) Signature of patient (or legal guardian)

_______________________________________ Date: ________________.
Chiropractor Signature

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Electronic Direct Billing Authorization & Consent Form

Cornerstone Therapy & Wellness is set up to bill directly to most insurance companies. Please note that all extended healthcare plans are different and not all plans allow for electronic submission or assignment of benefits. In the event that your plan does not allow for the above, you are responsible for paying the full amount of your visit. In some cases, Cornerstone Therapy & Wellness can bill your visit on your behalf so that you will be paid directly by your insurance provider.

As healthcare providers, we do not have access to your coverage details. You are responsible for knowing the details of your coverage including (but not limited to): services covered, amount covered per visit, and yearly coverage allowance.

Insurance Information

Insurance Provider: ____

Primary Plan Member: ____

Plan/Contract Number: ____

Member ID Number: ____

Please sign:

I authorize Cornerstone Therapy & Wellness to collect, use and disclose personal information concerning any claims submitted on my behalf to those authorized under applicable law. In the event there is suspicion of fraud or plan abuse concerning claims submitted, I acknowledge and agree that Cornerstone Therapy & Wellness may use and disclose any relevant personal information for the purposes of investigation and prevention of fraud and/or plan abuse.

I give Cornerstone Therapy & Wellness permission to electronically bill my visit on my behalf. I also consent that, should my plan allow for assignment of benefits, Cornerstone Therapy & Wellness can be paid by my insurance provider directly. I also acknowledge that my insurance plan may not cover the full cost of my visit, and therefore agree to pay any costs that are not covered by my insurance provider.

Print name: ____

Signature: ____

Date (D/M/Y): ________________________