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)*:____

Age: _____ Gender: ☐Female ☐Male Do we have permission to send you e-blasts? ☐ Yes ☐ No

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: ____

Do we have permission to send updates and reports to your family doctor? ☐ Yes ☐ No

Chiropractic:

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

Massage/Athletic Therapy/Personal Training:

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

Physiotherapy:

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

Other Services:

Custom Orthotics:	$400.00

All prices include tax (where applicable)

Services provided are not covered by OHIP

CORNERSTONE THERAPY & WELLNESS

CONSENT TO PHYSIOTHERAPY EXAMINATION:

The risks associated with a Physiotherapy examination include, but are not limited to, short term aggravation of symptoms or muscle soreness. Treatment techniques may include manual techniques, spinal manipulation, therapeutic exercise, acupuncture, electrotherapeutic modalities, as well as other techniques and procedures that may improve your function. Your physiotherapist will explain the benefits, side effects and potential complications of each chosen technique.

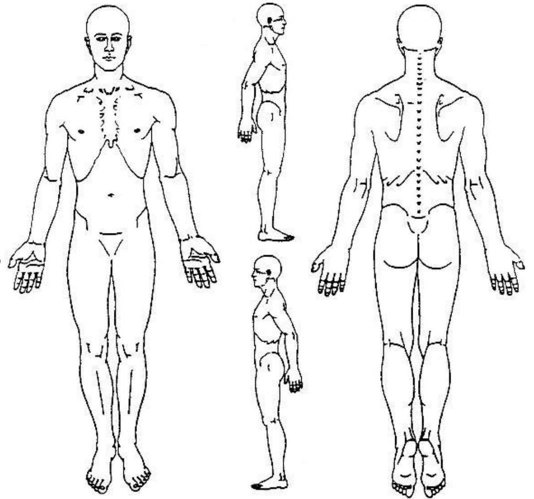
If you are not comfortable, you may stop the examination at any time. Please be involved in and take responsibility for your care. Inform your Physiotherapist immediately of any change in your condition. I hereby consent to the Physiotherapy examination and subsequent treatment.

Print Patient Name:____

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

Physiotherapist 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 Dic
☐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) _______/_______/____________

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

All Information provided is confidential

CORNERSTONE
THERAPY & WELLNESS

Informed Consent for Acupuncture Treatments

Please read carefully

I hereby request and consent to assessment and performance of acupuncture and other related techniques, as necessary, including electroacupuncture by a regulated Physiotherapist (MScPT) and certified acupuncturist through the Acupuncture Foundation of Canada Institute (CAFCI).

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea or fainting. These symptoms are temporary in nature. On rare occasions, infection, convulsions, possible perforation of internal organs, and stuck or bent needles could occur.

I have been advised that **only single use, sterile, disposable needles are to be used.** All acupuncture needles are properly disposed of after each and every treatment.

I do not expect the acupuncture practitioner to be able to anticipate and explain all possible risks and complications. I wish to rely on the practitioner to exercise judgment during the course of the treatment, which he/she feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

Prior to treatment, I will have had a light meal and will avoid smoking and consumption of alcohol or caffeine for a few hours before and after treatment. I will continue to take medications as prescribed by my doctor throughout the course of acupuncture treatment.

I have read the above consent form. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above-mentioned acupuncture procedures.

N.B. Female Patients: I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant. I will notify the Physiotherapist should I become pregnant during treatment.

________________	________________________________	_________________________
Date Signed	Print Name	Signature

____

Witness

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): ________________________

All Information provided is confidential