CORNERSTONE
THERAPY & WELLNESS

PATIENT INTAKE FORM

_____ **I understand that <u>24 hours notice is required</u> to cancel any appointments, otherwise I will be** *(initials)* **charged for the entire cost of the missed/cancelled visit.**

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

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

Address: _____ City:_____ Postal code:_____

Phone (Home):_____ Phone (Cell):_____

Emergency Contact _____ Phone: _____ Relationship: _____

<u>GUARDIAN (Please complete if under 16 years of age):</u>

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

Age: _____ Address same as above? ☐ Yes ☐ No, _____

City:_____ Postal code:_____ Phone:_____

Guardian Signature: _____ _____ Date: _____

<u>PRIMARY CARE PHYSICIAN:</u>

Physician name: _____ Phone: _____

Address: _____

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

<u>FEE SCHEDULE:</u>

Chiropractic:		**Massage/Athletic Therapy:**	
Initial Exam:	$90.00	30-minutes:	$65.00
Non-Complex Treatment:	$45.00	45-minutes:	$80.00
Complex Treatment:	$55.00	60-minutes:	$95.00
Laser Therapy:	$55.00	90-minutes:	$135.00
Physiotherapy:		**Other Services:**	
Initial Exam:	$90.00	Custom Orthotics:	$400.00
Treatment:	$75.00	*All prices include tax (where applicable)*	
New Injury Assessment:	$90.00	*Services provided are not covered by OHIP*	

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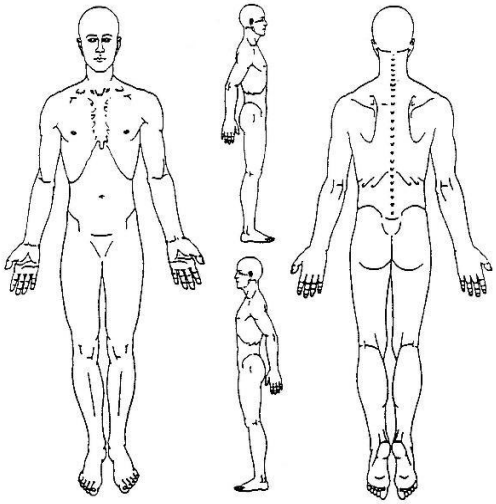
FAMILY HISTORY: Have your grandparents, parents or siblings ever been diagnosed with any of the following?

□ 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: _____

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: _____

Medications/supplements you currently take:_____

Allergies:_____

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

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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
☐Bronchitis
☐Cancer
☐Chest Pain
☐Chronic fatigue
☐Chronic Congestive Heart Failure
☐Chronic Cough
☐Cold hands/feet
☐Diabetes
☐Digestive problems
☐Swelling, Stiffness of Joints
☐Shortness of Breath
☐TB
☐Dizziness/Vertigo
☐Epilepsy
☐Emphysem
☐Falls/Head injuries
☐Headaches
☐Hepatitis
☐Heart Disease
☐Hearing, Vision loss
☐Herniated Disc
☐HIV
☐Herpes
☐High/Low Blood Pressure
☐Jaw Pain/TMJ
☐Allergy
☐Scoliosis
☐Stroke
☐Tinnitus (Ear Noises)
☐Pacemaker
☐Osteoporosis
☐Pain –Neck
☐Pain – Mid Back
☐Pain- Arm/Elbow
☐Pain – Hand
☐Pain – Wrist
☐Pain – Shoulder
☐Pain – Ankle or Foot
☐Pain – Leg
☐Pain – Knee
☐Varicose Veins
☐Other_____

PLEASE FILL OUT:

Have you ever had an accident (car, fall, sport, other)? ☐No ☐Yes

Please describe: _____

Have you ever had an operation? ☐No ☐Yes

Please describe: _____

Have you ever had a fracture? ☐No ☐Yes

Please describe: _____

Have you ever been hospitalized? ☐No ☐Yes

Please describe: _____

Have you ever experienced loss of sensation ☐No ☐Yes

Please describe: _____

Have you ever been diagnosed with any other medical conditions? (e.g. digestive conditions, haemophilia, mental illness, ect.): _____

Do you have any internal pins, wires artificial joints, or special equipment? ☐No ☐Yes

Please describe: _____

What is the reason you are seeking massage therapy?

Please describe: _____

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All Information provided is confidential

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Informed Consent

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

I will have an opportunity to discuss with my therapist the nature and purpose of the treatment procedure(s). I am aware that modalities and therapeutic tools may be used as part of my treatment at the discretion of my therapist and I consent to the use of these tools once my therapist 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 further understand that, as in all health care there are some very slight risks to treatment, including but not limited to; muscle strains and sprains, disc injuries, and strokes. I do not expect my health professional to be able to anticipate and explain all the risks and complications.

I acknowledge and understand that my therapist 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 to lotions, oils or scented products before my treatment begins, or to let my therapist 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 therapist 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 therapist about any aspect of my treatment.

Proper draping is always provided to ensure safety, comfort and privacy for all clients. Clients will be asked to disrobe to suit their comfort level in privacy and prepare themselves on the table. The therapist respects your right to modify, refuse or terminate your consent at any time, regardless of prior consent given. This clinic respects the confidentiality of all client 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 I have had the opportunity to question the consent and my therapy. 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.

_____

Print Name

_____ _____

Signature Date

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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): _____

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