NURTURING HEALTH
Naturopathic Clinic

18 Spencer Street East
Cobourg, ON
K9A 1C2

PHONE: 905-372-2369 FAX: 905-372-4977

-Intake Form-

All information is retained as part of your confidential patient record.

PATIENT INFORMATION

Last Name: _____ First Name:_____ Sex: □M □F

Parent/Guardian Name: _____

Address:_____ City:_____ Postal Code:_____

Home Phone: _____Work Phone: _____ Cell:_____

Email: _____

Occupation:_____ Employer: _____

Date of Birth (dd/mm/yy):_____ Family Doctor:_____

Emergency Contact: _____Relationship:_____ Phone: _____

PATIENT MEDICAL HISTORY

In order to ensure safe and optimum care your physiotherapist requires the following information. This information will be kept strictly confidential.

What problem(s) would you like assessed and treated?

_____
_____

How long has this been a problem?: _____

How does it affect your life?:

_____
_____
_____
_____

Have you received treatment for this?:
□ Yes □ No
If yes, where did you receive this treatment?

_____

Have you had any of the following recently?
□ X-ray □ MRI □ Ultrasound □ CT scan

Please list all current medications. If list is long we can photocopy.

_____
_____
_____
_____

Do you have or have you ever been treated for (check all that apply) :
□ Diabetes □ Heart Disease □ Arthritis □ Stroke
□ Cancer □ Shortness of Breath □ Blood Disease
□ Thyroid problem □ Digestive Problem
□ Skin disorder □ Urinary problems/Leakage
□ Bowel trouble □ Pain with sex/tampon
□ High blood pressure □ Anxiety/Depression
□ HIV/AIDS □ Epilepsy □ Lung Disease
□ Pacemaker □ Osteoporosis □ Smoker
□ Concussion □ Blood thinners □ Headaches
□ Dizziness □ Hepatitis □ Steroid use
□ Sensation Loss □ Metal implants

□ Bone scan □ EMG □ Urinalysis □ Other _____ If yes, **Location?:**_____ **Date?:**_____ **What are your goals for treatment?:** _____ _____ _____	□ Circulatory Problems □ Allergies _____ □ # of pregnancies_____ □ # of live births_____ □ Delivery Method (s) (V/C/VBAC) □ Delivery Complications _____ □ Other _____ **Please list surgeries and dates:** _____ _____ _____ _____ _____

BILLING

I understand that I am responsible for payment for services received at Nurturing Health. If my claim is to be submitted directly to an outside agency for payment, and the third party payer denies or refused to pay for any of the amount billed, I will ensure paying the outstanding amount.

Nurturing Health respectfully requires patients to provide 24 hours notice for appointment cancellations. Failure to do so may result in a cancellation fee that I am responsible for.

CONSENT FOR TREATMENT

I, _____, voluntarily consent to being assessed and treated by a Registered Physiotherapist and I understand that I may withdraw from treatment at any time.

CONSENT TO RELEASE INFORMATION

I, _____, hereby authorize Nurturing Health to release information pertaining to my treatment and condition to the following (please check and provide information)

□ Doctor(s)_____□ Insurance Company _____

□ Employer _____ □ Lawyer _____

Nurturing Health is the Health Information Custodian (HIC) who ensures your personal information is collected, used, stored and disclosed appropriately.

How did you hear about Sherry Heenan? _____

Signature: _____ Date: _____