OMNI HEALTH AND REHAB CLINIC

# Patient Intake Form

## Patient Information

| | | |
|---|---|---|
| Last Name: | First Name: | Middle Initial: |
| Address: | City: | Postal code: |

| | | |
|---|---|---|
| Home Phone Number: | Cell Phone Number: | E-Mail Address: |

| | | | |
|---|---|---|---|
| Date Of Birth: | Sex: ☐ Male ☐ Female | How did you hear about us: | Shoe Size: |
| Current Activity Level: 1 2 3 4 5 6 7 8 9 10 | Current Job: | If you aren't currently employed , when was the last day you worked: | |

## Extended Insurance Information

| | | |
|---|---|---|
| Primary Insurance Company:<br>1.<br>2. | ID Number:<br>1.<br>2. | Policy Number:<br>1.<br>2. |
| Policy Holder: ☐ Same As Patient ☐ Different benefactor(If so please print full name & date of birth Bellow):<br>Policy Holders Name:<br>Policy Holders Date of Birth: | | Relationship To Patient: |

## Physicians Information

| | | |
|---|---|---|
| Name Of Family Physician: | Location Of Office: | Physicians Phone Number: |
| Do we have your consent to contact your doctor in regards to your case: ☐ Yes ☐ No | | |

## Emergency Contact Information

| | | | |
|---|---|---|---|
| Contacts First Name: | Contacts Last Name: | Contacts Phone Number: | Relationship To Patient: |

## Additional Questions

| | |
|---|---|
| What are your goals for treatment: | is your injury a result of : ☐ Work Place injury ☐ Neither<br>☐ Motor vehicle Accident (please fill out the following section) |

## Motor Vehicle Accident

| | | | |
|---|---|---|---|
| Auto Insurance Company: | Date Of Accident: | Claim Number: | Policy Number: |
| Adjusters First Name: | Adjusters Last Name: | Adjusters Phone Number: | Adjusters Extension: |
| Law Firm: | Legal Representative: | Phone Number: | |

Intake Form Completed By (Print Name)

Date of Completion

I, Acknowledge that the above Information is correct
(Please sign)

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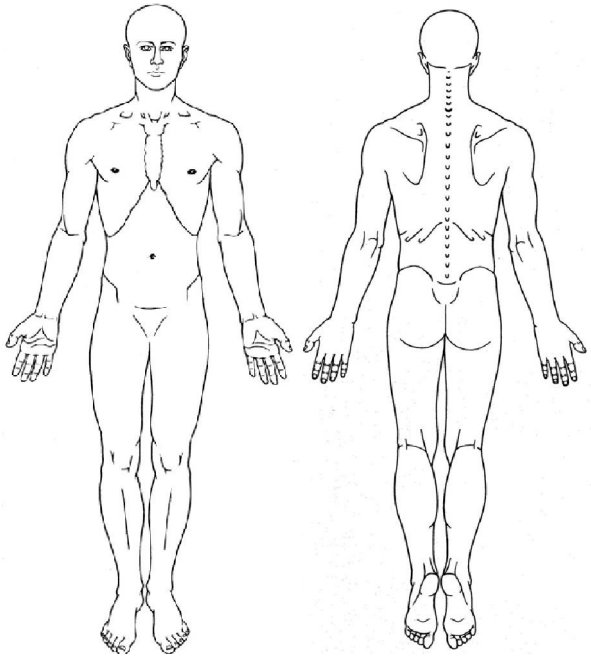
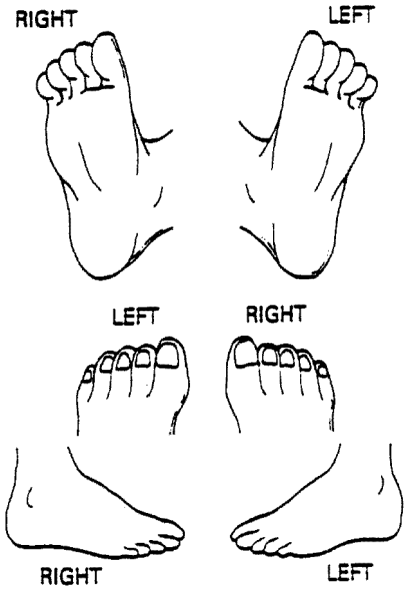
Please indicate the area of pain using the symbols to the right






Numbness

- - - - - - -

Burning

^ ^ ^ ^ ^

Aching Pain

X X X X

Stabbing Pain

O O O O

Please mark each item below for each sign or symptom you presently have or previously had:

## Genito-Urinary

__ Blood in Urine
__ Frequent Urination
__ Kidney Infection
__ Painful Urination
__ Loss of Bladder Control

## Gastro-Intestinal

__ Nausea
__ Abdominal Pain
__ Vomiting
__ Weight Loss/Gain

## Dermatological

__ Psoriasis
__ Lesions
__ Fungus
__ Warts

## Muscles & Joints

__ Low Back Problems
__ Pain between Shoulders
__ Neck Problems
__ Arm Problems
__ Leg Problems
__ Swollen Joints
__ Painful Joints
__ Stiff Joints
__ Sore Muscles
__ Weak Muscles
__ Walking Problems
__ Sprains/Strains

## Communicable Diseases

__ HIV
__ AIDS
__ HEP C

## For Women Only

__ Birth Control Pill
__ Hormone Replacement
__ Painful Periods
__ Breast Pain
Pregnant at this Time Y/N

## Cardio-Vascular

__ High Blood Pressure
__ Heart Attack
__ Angina
__ Strokes
__ Swollen Ankles
__ Varicose Veins

## Respiratory

__ Asthma
__ Chronic Cough
__ Difficulty Breathing
__ Spitting Blood
__ Spitting Phlegm

## General Symptoms

__ Dizziness
__ Fainting
__ Headache
__ Nervousness
__ Numbness

Presence of internal pins, wires, artificial STS, special Equipment __Yes __No

I, the patient (undersigned), consent to assessment/treatment and agree to it being necessary or advisable. I give permission to the clinic to contact my family physician to discuss my management plan. I give permission to have digital images taken when necessary so as to monitor the progress of the treatment. I understand that my treatment is not covered by OHIP. I am solely responsible for all fees and charges associated with the treatment regardless of insurance or extended health coverage. In an event when coverage is declined I agree to pay of all services rendered. I certify that all of the above information is complete and correct.

| Form completed By (Please Print Name) | Date of Completion | I, Acknowledge that the above Information is correct (Please sign) |
|---|---|---|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Website: www.omniclinic.ca

I, _____have read and understand the declared policies and information. I allocate my consent for the duration of my entire course of treatment. Milton Health and Wellness center can contact my family physician and Insurance Company when it pertains to my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I give permission to have digital images taken when necessary so as to monitor the progress of the treatment. I understand that my treatment is not covered by OHIP. I am solely responsible for all fees and charges associated with the treatment regardless of insurance or extended health coverage. In an event when coverage is declined I agree to pay for all services provide.

| _____ | _____ | _____ |
|---|---|---|
| Form Completed By (Print Name) | I, Acknowledge that the above Information is correct (Please sign) | Date of Completion |