Coquitlam Integrated Health

A – 2976 Glen Drive, Coquitlam, BC V3B 0G5 | F. 604.941.5486 | T. 604.941.5483
www.coquitlamintegratedhealth.ca | email: infocih@telus.net

PATIENT INTAKE FORM

(By filling out this form, it enables us to provide you with the most effective care. Thank you for your cooperation.)

Date of Visit: _____

Full Name _____ I go by: _____
(last) *(first)*

Care Card (PHN #) _____ Male ☐ Female ☐

Birthday (mm/dd/yy) _____ Age: _____ Marital Status: S __ M __ D __ W __ L/W __

Spouse/Partner's Name: _____ Ages of children if any: _____

Address _____
(Apt. No) *(Street)* *(City)* *(Postal Code)*

Phone Numbers: _____
(Home Phone) *(Cell Phone)*

Email: _____ Reminder email? Yes ☐ No ☐

Occupation _____ Work Tel. _____

Company name: _____ May we call you at work? Yes ☐ No ☐

Your GP's Name (MD) _____ Tel. _____

Emergency Contact (and relation): _____ Tel. _____

Is your condition part of an ICBC or WCB claim? If YES, please indicate the following:

Adjuster's Name: _____ Tel. _____

Claim No: _____ Lawyer's Name/Tel: _____

Where did you hear about our clinic?

☐ Internet ☐ Yellow Pages ☐ Friend/Relative ☐ MD

☐ Other Practitioner *Name:* _____

Cancellation Policy: *We set dedicated time in our office for all appointments. If you find it necessary to cancel, please provide 24-hour advance notice. Without notice, you will be charged 50% of the applicable treatment fee.*

☐ *Please initial once you have read*

HEALTH ISSUES QUESTIONNAIRE:

Main Concerns:

How long have you had this condition(s)?

Have you been given a diagnosis by your GP? If YES, what is that diagnosis?

Have you tried any of the following treatments before?

☐ Acupuncture ☐ Massage Therapy ☐ Chiropractic ☐ Laser Therapy

Other treatments?

MEDICATIONS (include prescriptions and over-the-counter/include dosage)

☐ Anti-inflammatory ☐ Muscle Relaxants ☐ Laxatives ☐ Anti-depressants

☐ Pain killers ☐ Sleeping pills ☐ Other ☐ Supplements (Herbs, gingko, other vitamins)

Additional details:

MAJOR INJURIES AND ILLNESSES/ACCIDENTS/ALL SURGERIES (indicate dates and nature of each)

LIFESTYLE QUESTIONS (indicate with an X on a scale of 0 to 10: 0 – NONE ; 10 – HIGH)

Stress:	0 1 2 3 4 5 6 7 8 9 10	Exercise/week:	0 1 2 3 4 5 6 7 8 9 10
Smoke:	0 1 2 3 4 5 6 7 8 9 10	Alcohol:	0 1 2 3 4 5 6 7 8 9 10
Coffee:	0 1 2 3 4 5 6 7 8 9 10		

FAMILY MEDICAL HISTORY

☐ Allergies	☐ Cancer	☐ Diabetes	☐ Hepatitis	☐ Thyroid Disease
☐ Seizures	☐ Heart Disease	☐ Stroke	☐ Venereal Disease	
☐ Thyroid Disease	☐ Varicose Veins	☐ Rheumatic Fever	☐ High/Low Blood Pressure	

FOR WOMEN ONLY

Are you pregnant? YES / NO / MAYBE If YES, when is your due date? _____

Do you have children? YES / NO If YES, was it: Vaginal birth / Caesarean birth

Menstrual cycle: Regular / Irregular / Painful Cycle

Date of your last annual Pap/Breast exam: _____

Review of systems Please check the appropriate box for any of the following symptoms and add any comments you may feel are important.

Key: **P**=Past **N**=Now **B**=Both

P N B

General
☐☐☐ Insomnia
☐☐☐ Fatigue
☐☐☐ Weight loss
☐☐☐ Weight gain

Head
☐☐☐ Headache
☐☐☐ Dizziness
☐☐☐ Head trauma
☐☐☐ Fainting

Eyes
☐☐☐ Itching/redness
☐☐☐ Cataracts
☐☐☐ Flashes in vision
☐☐☐ Spots in vision
☐☐☐ Glaucoma

Mouth and Throat
☐☐☐ Bleeding gums
☐☐☐ Canker sores
☐☐☐ Colds sores
☐☐☐ Sore throat
☐☐☐ Jaw/TMJ problems
☐☐☐ Hoarseness
☐☐☐ Goiter

Nose
☐☐☐ Hayfever
☐☐☐ Loss of smell
☐☐☐ Nosebleeds
☐☐☐ Sinus problems

Lungs
☐☐☐ Shortness of breath
☐☐☐ Persistent cough
☐☐☐ Loss of smell
☐☐☐ Nosebleeds
☐☐☐ Sinus problems

Vascular
☐☐☐ Angina
☐☐☐ Murmurs
☐☐☐ Chest pain
☐☐☐ Palpitations
☐☐☐ Ankle swelling
☐☐☐ Cold feet/hands
☐☐☐ Leg cramps
☐☐☐ Varicose veins
☐☐☐ Low blood pressure
☐☐☐ High blood pressure

P N B

Gastro-Intestinal
☐☐☐ Bloating/gas
☐☐☐ Heartburn
☐☐☐ Ulcers
☐☐☐ Liver disease
☐☐☐ Gallstones
☐☐☐ Vomiting/nausea
☐☐☐ Abdominal pain
☐☐☐ Diarrhea
☐☐☐ Constipation
☐☐☐ Blood in stool
☐☐☐ Hemorrhoids
☐☐☐ Hernias
_____ # of bowel movements per day

Gastro-Urinary
☐☐☐ Difficulty urinating
☐☐☐ Pain urinating
☐☐☐ Blood in urine
☐☐☐ Incontinence
☐☐☐ Bed-wetting
☐☐☐ Frequent urination
☐☐☐ Frequent infections
☐☐☐ Kidney stones

Neurological
☐☐☐ Seizures/epilepsy
☐☐☐ Strokes
☐☐☐ Tingling sensation
☐☐☐ Numbness
☐☐☐ Muscle weakness
☐☐☐ Difficulty walking
☐☐☐ Poor coordination
☐☐☐ Paralysis
☐☐☐ Speech problems
☐☐☐ Loss of memory

Muscle & Bone
☐☐☐ Joint pain
☐☐☐ Swollen joints
☐☐☐ Stiffness
☐☐☐ Muscle ache
☐☐☐ Foot trouble
☐☐☐ Bone pain
☐☐☐ Fractures
☐☐☐ Dislocations

P N B

Skin
☐☐☐ Rash
☐☐☐ Itching
☐☐☐ Hives
☐☐☐ Change in moles
☐☐☐ Acne
☐☐☐ Psoriasis
☐☐☐ Eczema

Endocrine
☐☐☐ Diabetes
☐☐☐ Hypoglycemia
☐☐☐ Hormone therapy
☐☐☐ Thyroid problems
☐☐☐ Heat/cold intolerance
☐☐☐ Excessive thirst
☐☐☐ Excessive hunger
☐☐☐ Excessive sweating
☐☐☐ Night sweats

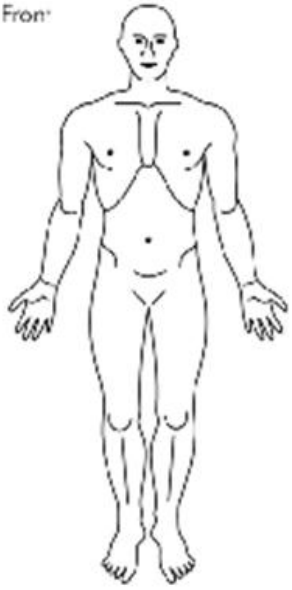
Emotional
☐☐☐ Depression
☐☐☐ Mood swings
☐☐☐ Anxiety/nervousness
☐☐☐ Tension
☐☐☐ Phobias

Conditions
☐☐☐ AIDS/HIV
☐☐☐ Eating disorders
☐☐☐ Heart disease
☐☐☐ Rheumatic fever
☐☐☐ Cancer/tumor
☐☐☐ Polio
☐☐☐ Parkinson's
☐☐☐ Multiple sclerosis
☐☐☐ Gout
☐☐☐ Anemia
☐☐☐ Osteoporosis
☐☐☐ Osteoarthritis
☐☐☐ High cholesterol
☐☐☐ Fibromyalgia
☐☐☐ Chronic fatigue
☐☐☐ Hepatitis
☐☐☐ Migraines
☐☐☐ TIAs

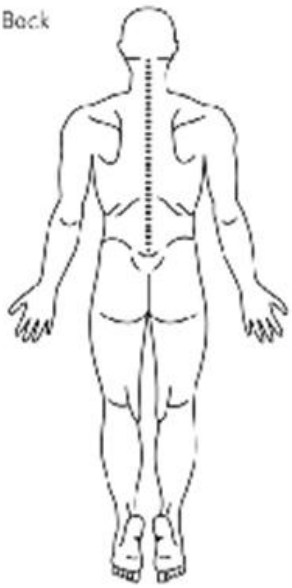
Using the following symbols, please indicate directly on the body diagrams below the area of your complaint and the type of pain experienced.

X Burning O Dull/achy
△ Sharp ☐ Numbness/tingling

Front



Back



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PATIENT CONSENT

Your registered massage therapist (RMT) will make every effort to ensure that your treatment is safe and effective. At any time, before or during therapy you have the right to ask that the treatment, or portions of the treatment, be discontinued, or inquire about the purposes of any technique being used. If at any time you have questions or concerns related to the treatment, we encourage you to communicate with your therapist so there is clarification or modification of the treatment.

Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours notice of cancellation, or a cancellation fee will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the patient.

I authorize the clinic and its associated RMTs to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated RMTs to communicate with my MD and other health care practitioners as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature: _____ Date: _____