Coquitlam Integrated Health

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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 (Same as Care card) _____ I go by: _____

(First) (Middle) (Last)

Care Card (PHN #) _____ Male ☐ Female ☐

Birthday (mm/dd/yy) _____

Address _____

(Apt. No) (Street) (City) (Postal Code)

Phone Numbers: _____

(Home) (Cell Phone)

Email: _____

Reminder: Phone: Email Text

Family Doctor' Name&Contact: :

Emergency Contact (and relation):

Extended Health Insurance Name:

Policy # ID #

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

Adjuster's Name: Tel.

Claim No: Have you had any prior treatments under this claim?

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.*

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: _____