Patient Health Summary

Bernadette Britton R.Ac.| Acupuncturist | Registration #6763
Resolution Physiotherapy & IMS Clinic
Suite 218, 11 Victoria St., Barrie, ON L4N 6T3
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Initial Intake Form

Today's Date: ___/___/_____

Patient Information		
First Name:	Last Name:	Middle Name:
Telephone (Home/Mobile):	Telephone (Business):	Sex: M / F / Other
Home/Street Address:	Apt #:	Date of Birth: (DD/MM/YY)
City: Province:	Postal Code:	Marital Status:
Occupation:	Email:	
Family Contact Information	First name:	Last name:
Relationship to Patient:	Phone Number:	Mobile Number:
Emergency Contact information (If different individual from above)	First name:	Last Name:
Relationship to Patient:	Phone Number:	Mobile Number:
Family Doctor Name:		
Clinic Address:		
Clinic Phone:	Clinic Email:	

Past Medical History

Please list any relevant past medical history including any hospitalizations, surgeries, prior injuries, or any past medical conditions etc. Be sure to include any previous family medical conditions or diseases that may be relevant.

Ongoing Health Conditions/ Allergies/Drug Reactions/ Risk Factors/Long Term Treatment
Please list any ongoing health conditions, allergies, drug reactions, and long-term treatments that may be relevant. If you are currently taking any prescription medications, please include them.

Please highlight any conditions you are experiencing (past and present):

General Symptoms
Headaches/migraines
Fever
Chills
Sweat
Memory loss
Dizziness/Light headiness
Fainting
Stress/depression
Discoordination
Nervousness
Numbness/pain in arms/legs

Respiratory
Wheezing
Chronic Cough
Chronic Cough
Spitting up phlegm
Chest pain
Difficulty breathing

Muscle and Joint
Stiff neck
Back ache
Swollen joints
Painful tailbone
Pain in shoulder
Hernia
Spinal curvature
Faulty posture
Arthritis
Foot trouble

Cardiovascular
High or low blood pressure
Previous stroke or TIA
High cholesterol
Swelling of ankles
Poor circulation
Stroke/Heart attack
Irregular heartbeat
Shortness of breath
Pain over heart

Genitourinary System
Frequent/painful urination
Blood in urine/stool
Kidney infection/stones
Bladder infection
Inability to control urine

Ears, Eyes, Nose, Throat
Hearing loss
Vision problems
Glaucoma
Ringing in ear(s)
Crossed eyes
Eye pain
Deafness
Earache
Ear discharge
Nose bleeds
Nasal obstruction
Sore throat
Hoarseness
Hay fever
Asthma
Dental decay
Gum concerns
Frequent colds
Enlarged thyroid
Tonsilitis
Sinus infection
Nasal drainage
Enlarged glands

Skin
Skin conditions/rashes
Itching
Bruise easily
Dryness
Varicose Veins
Sensitive skin
Hives or allergy

Gastrointestinal
Poor appetite
Distress from greasy/ acidic foods
Excessive hunger
Excessive thirst
Belching or gas
Pain over stomach
Constipation/diarrhea
Colon concerns
Liver concerns
Gall bladder concerns
Ulcers
Colitis
Hemorrhoids
Hypoglycemia
Hiatal Hernia
Metallic taste

For Women Only
Cramps/back ache
Previous miscarriage
Irregular cycle
Vaginal discharge
Lumps in breast
Menopausal symptoms

Pregnant
Painful menstruation
Excessive flow
Clotting
Hot flashes
Hysterectomy

For Men Only
Prostate concerns
Low libido
Impotence
Premature ejaculation

Have you had any of the following conditions? Please highlight all that apply.

Appendicitis	Malaria	Chicken pox	Alcoholism	Osteoporosis
Diabetes	Venereal infection	Cold sores	Whooping cough	Cancer
Epilepsy	Multiple sclerosis	Anemia	Heart disease	Tuberculosis
Pneumonia	Measles	Goiter	Eczema	Mental Illness
Mumps	Influenza	Gout	Polio	Pleurisy
Pneumatic fever	Arthritis	Rubella	Parkinson's	HIV/AIDS

Please list your main health concern(s) in order of importance to you: _____

_____

_____

What are your 3 main goals for health and well-being?

_____

_____

_____

_____ _____

Patient Signature Date

_____ _____

Substitute Decision Maker Relationship to Patient

Consent to Collect, Use, and Disclose Personal Health Information

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I _____, or my Substitute Decision-Maker _____
Print name Print name if applicable

☐ Consent ☐ Do not consent

For Resolution Physiotherapy & IMS Clinic to collect, use and disclose my personal health information for the purpose of providing acupuncture to me and for the related purposes set out in Resolution Physiotherapy & IMS Clinic Written Privacy Statement. The personal health information that may be collected, used or disclosed by the Clinic may include the following, among other things:

- My birth date and contact information
- My health history and family health history
- My health status
- The health care I receive (including identifying my health care provider(s));
- My health number
- The identification of my Substitute Decision-Maker, if any
- Insurance or billing information relating to health care

I understand that there may be situations in which practitioners at Resolution Physiotherapy & IMS Clinic will have to collect, use or disclose personal health information without my consent, but that they will only do this if permitted by law.

How My Information Will Be Used

I understand that my personal health information may be collected, used or disclosed for the following reasons:

- To provide me with acupuncture services
- To obtain payment for services provided
- To assist insurance companies with insurance claims verification
- To seek advice for potential treatment options
- To provide or arrange health care in cases of emergencies
- To fulfill any obligations as mandated by law

Patient Access to Information

I understand that my personal health information is available to me for my review except in limited circumstances as permitted by law. I also understand that I can ask to have my personal health information corrected if I believe there is a mistake in the records, with some exceptions.

Acknowledgment

I allow Resolution Physiotherapy & IMS Clinic to collect, use and disclose my personal health information as outlined above.

I understand that I can access my personal health information with some limited exceptions.

I understand that I am not required to sign this form and that I can withdraw my consent at any time by contacting Bernadette Britton R.Ac., but it may directly affect the services I can receive. My personal health information may still be collected, used or disclosed if permitted by law.

Additional Comments or Restrictions:

_____

_____

_____

_____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____