n-Site Medical

MEDICAL INTAKE FORM

Date:

PLEASE PRINT AND COMPLETE ALL ENTRIES		
LAST NAME:	FIRST NAME:	DATE OF BIRTH:
ADDRESS: STREET	APT/UNIT #	PROVINCE & CITY NL
POSTAL CODE	HOME PHONE NUMBER	CELL PHONE NUMBER
E-MAIL ADDRESS		
EMERGENCY CONTACT PERSON	RELATIONSHIP	PHONE NUMBER
FAMILY DOCTOR	PHONE NUMBER	DATE OF ACCIDENT:

COVERAGE TYPE			
☐ NO COVERAGE	☐ EXTENDED HEALTH BENEFITS	☐ MOTOR VEHICLE ACCIDENT (ADDITIONAL INFORMATION IS REQUIRED)	☐ WORKPLACE INJURY (ADDITIONAL INFORMATION IS REQUIRED)

EXTENDED HEALTH BENEFITS INFORMATION		
NAME OF INSURANCE COMPANY	NAME OF POLICY HOLDER SELF ☐	POLICY HOLDER DATE OF BIRTH
RELATIONSHIP TO PATIENT	POLICY NUMBER	ID / CERTIFICATE NUMBER
NAME OF EMPLOYER		

AUTO INSURANCE INFORMATION		
POLICY HOLDER NAME	NAME OF AUTO INSURANCE COMPANY	POLICY NUMBER

PLEASE INDICATE THE CONDITIONS YOU ARE EXPERIENCING OR HAVE EXPERIENCED:

RESPIRATORY

- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

CARDIOVASCULAR

- ☐ High or Low Blood Pressure
- ☐ Heart Attack
- ☐ Phlebitis
- ☐ Stroke / CVA
- ☐ Pacemaker or similar device
- ☐ Heart Disease
- ☐ Easy Bruising – use of blood thinning medication
- ☐ Varicose Veins
- ☐ Blood Clots or Clotting Disorder

INFECTIONS

- ☐ Hepatitis
- ☐ TB
- ☐ HIV / AIDS
- ☐ Skin
- ☐ Other

WOMEN

- ☐ Pregnant (Due):
- ☐ Menstrual Backache
- ☐ Painful Periods
- ☐ Birth Control Method

SOFT TISSUE/JOINT DISCOMFORT

- ☐ Neck
- ☐ Low Back
- ☐ Mid Back Upper Back
- ☐ Shoulders Elbows
- ☐ Wrists / Hands Arms
- ☐ Hips
- ☐ Knees
- ☐ Ankles / Feet Legs
- ☐ Muscle Cramping Jaw
- ☐ Weakness or Paralysis
- ☐ Other

HEAD / NECK

- ☐ Vision Problems
- ☐ Ear Problems
- ☐ Head Trauma
- ☐ Headaches / Migraines
- ☐ Sinus Problems
- ☐ Past Whiplash Injury

OTHER CONDITIONS

- ☐ Diabetes
- ☐ Allergies
- ☐ Epilepsy
- ☐ Cancer
- ☐ Arthritis
- ☐ Spinal Conditions
- ☐ Skin Condition
- ☐ Chronic Fatigue
- ☐ Weight loss or gain
- ☐ Disc Herniation
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Bone Disease

OTHER CONCERNS

- ☐ Loss of sensation
- ☐ Numbness/Tingling
- ☐ Dizziness/Fainting
- ☐ Bladder or Bowel Change
- ☐ Severe Unremitting Pain
- ☐ Severe Night Pain
- ☐ Severe Spasm
- ☐ Fever, Night Sweats
- ☐ Unexplained Fatigue
- ☐ Pain w/cough or sneeze
- ☐ Numbness in the Saddle
- ☐ Difficulty speaking or Swallowing
- ☐ Recent Nausea or Vomiting
- ☐ Other

CURRENT MEDICATIONS:	
RECENT SPECIAL TESTING (BLOODWORK, X-RAYS, MRI ETC.):	
INJURIES / FRACTURES:	
SURGERIES:	
DO YOU SMOKE:	No ☐ Yes ☐ If yes, how many per day ☐
DO YOU EXERCISE:	No ☐ Yes ☐ If yes, how hours per day ☐ Type of Exercise
PRESENT INVOLVEMENT IN OTHER HEALTH CARE?	No ☐ Yes ☐
IF YES, WHAT OTHER THERAPY ARE YOU RECEIVING?	
DO YOU HAVE ANY OTHER MEDICAL CONDITIONS?	
OF SPECIAL NOTE: (PRESENCE OF INTERNAL PINS, WIRES, ARTIFICIAL JOINTS OR SPECIAL EQUIPMENT):	

Use of Personal Information

On-Site Medical collects, uses, discloses, retains and disposes of your personal information in compliance with federal and provincial privacy legislation and applicable college regulations. All staff members who come in contact with your personal information have signed a confidentiality form and have been trained in the appropriate use and protection of your information. We use and disclose your personal information in the following ways:

* To assess your health concerns, advise you of options and provide medical assessments
* To communicate with other treating healthcare providers, including your physician
* To obtain diagnostic test results pertinent to the condition for which you are requiring assessments
* To allow us to efficiently follow-up for an assessment, care and billing via phone, e-mail, addressed mail and voicemail
* To establish and maintain contact with you
* To complete claims for insurance purposes
* To invoice for goods and services
* Please bring to the clinic copies of paperwork you receive from any of your insurance companies
* To comply with the law
* To contact you from time to time regarding assessments, post-treatment, changes to services, surveys, clinic updates and by phone, e-mail or addressed mail and voicemail

☐ I would like to receive e-mail reminders of my appointments

Financial Responsibility

On-Site Medical will bill your insurance carrier on your behalf when we can verify that payment will be received by the clinic directly.

* When your insurance carrier sends payment directly to you or requires that you pay and submit your expenses

Consent for Assessment & Treatment

I give my consent to undergo assessment and treatment. I have had the chance to discuss with my healthcare provider(s) the risks and benefits for my particular condition.

☐ Clinician initials – Consent Confirmed After Assessment

Cancellation Policy

We appreciate 24 hours advance notice for any cancellations.
I have read the above details and give my informed consent below.

Name of Patient (please print)	Signature of Patient (or Guardian)	Date

Instructions: Download the form onto your computer. Open using Adobe Acrobat. Fill the form, save it and then email the completed form to: onsitemedical@outlook.com