



Patient Information

Date: _____

Ms. **Mrs.** **Mr.** **Dr.**

Birthdate _____ / _____ / _____
Day Month Year

First Name _____

Last Name _____

Street _____

Home Phone _____
Leave a message? Yes | No

City _____ **Postal** _____

Cell Phone _____
Leave a message? Yes | No

Family Physician _____

Occupation _____

Email Address _____

Email Reminders Yes | No

Text Reminders Yes | No

Email Receipts Yes | No

Wireless provider Bell | Telus | Rogers | Koodoo

Clinic Policies (on the reverse of these intake forms)

I have read and understand the policies _____

To provide the best possible care it is often necessary to communicate information regarding our clinical findings and treatments back to your family physician or to other therapists in our clinic. Your consent is required to release such information.

I consent to the communication agreement _____

Health Insurance Direct Billing

We offer direct billing to certain insurance companies, to take advantage of this option please provide your insurance information.

Provider: _____

Policy: _____

id: _____

How did you hear about our Clinic or Practitioners

Referred by: _____

Web Search

Yellow Pages

Signage

Pamphlet

Other: _____

Phone: 722-2300

Fax: 722-5676

Web: www.backpainclinic.ca

1A Anderson Avenue

St. John's NL

A1B 3E1

Patient & Practitioner Conduct

Conduct

Any patient displaying inappropriate behaviour, using aggressive or offensive language or failing to comply with a prescribed treatment plan may be dismissed from the clinic. If indicated authorities will be contacted immediately.

Practitioners are required to act in accordance with the regulations set by provincial and/or national licensing bodies. A patient's informed consent is required for all steps in the patient/practitioner interaction.

Scheduling

Setting an appointment is a commitment between both the patient and practitioner based on the needs of the patient and care to be provided by the practitioner. The timing, duration and content is decided by the practitioner with consent from the patient.

Changes to an appointment requires 24 hours notice. Appointment cancellations within 24 hours of the appointment are considered missed appointments. Arriving 10 minutes or later for an appointment is considered a missed appointment. A patient who has missed 2 appointments with one practitioner within a 60 day period will be required to pay a missed appointment fee for that practitioner. Consistently missing appointments can lead to dismissal from the clinic.

In the event of practitioner absence or clinic closure a general announcement will be made through our website, facebook and twitter accounts. Patients with affected appointments will be contacted directly. Affected appointments will not be considered missed appointments.

Fee for service

Patients are financially responsible for services received or products purchased at the St. John's Back Pain Clinic. These are not covered under any provincial health plan but are often covered under private health plans or through other third party payers. In some cases these costs can be billed on the patient's behalf to third party payers but it is not a guaranteed process.

The billing process may occur with every service provided or may be allowed to accumulate during a series of services at the discretion of the practitioner in consultation with the patient.

Pain Diagram

My main concern is: _____

Did this result from a

- Motor vehicle accident
 Workplace Injury

Please highlight where you feel the problem at its strongest.
 Use the following symbols on the diagram to add greater detail.

Aching or Stiff

○ ○ ○
○ ○

Sharp or stabbing

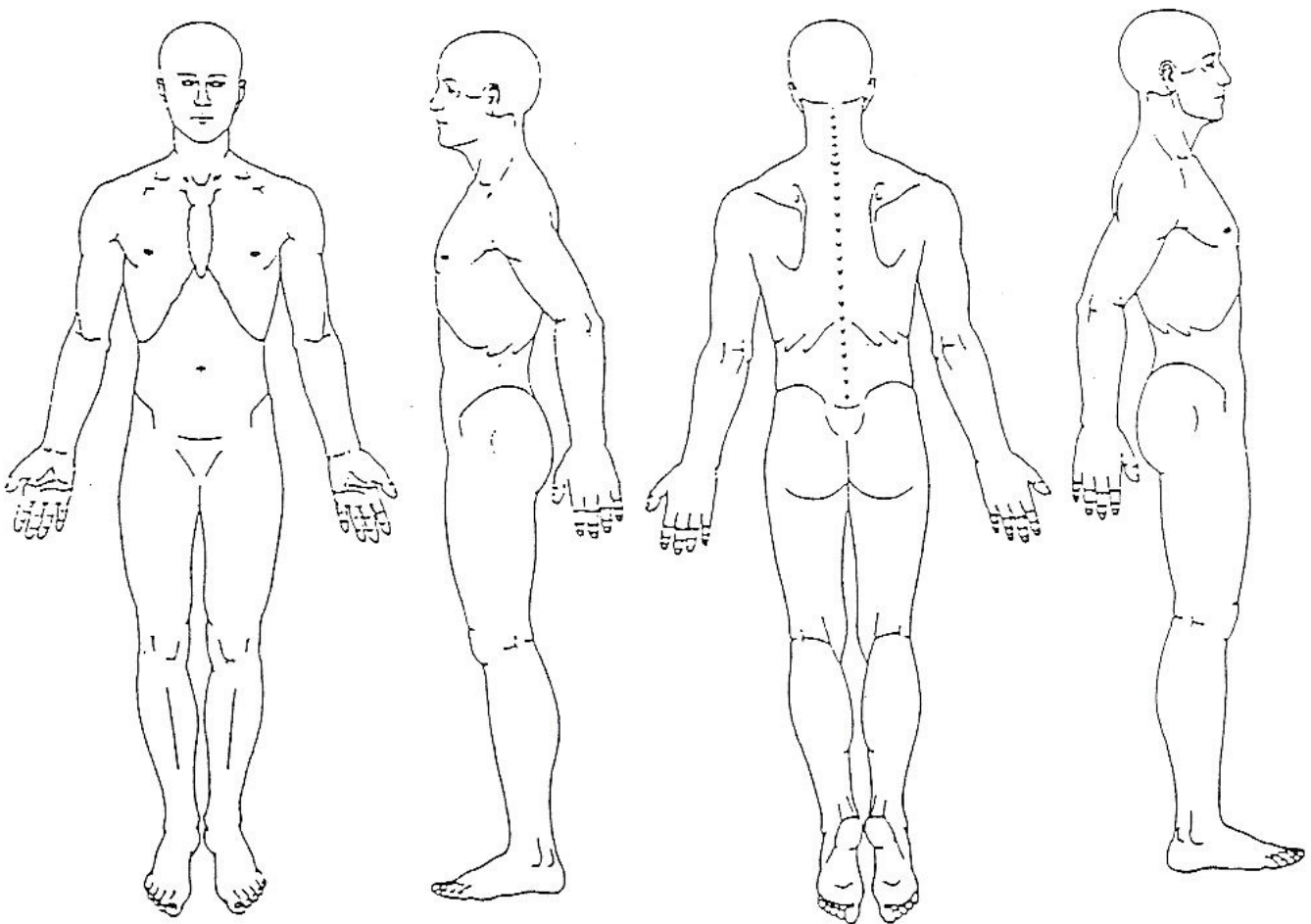
x x x
x x

Numb or tingling

. . .
. .

Burning

- - -
- -



Please indicate your current level of pain:

(No Pain) 1 2 3 4 5 6 7 8 9 10 (Worst Possible Pain)

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Privacy Policy

We Collect Personal Information

Like many health care providers we collect, use and disclose personal information in order to serve our patients. The primary reason we collect this information is to provide quality care. Contact information is collected to organize appointments and allow communication between patients and the clinic. Information is collected from a physical examination, discussion of health history, work, activities and lifestyle to better understand patients health needs and develop the most appropriate plan of care.

There are secondary reasons to collect, use and disclose information collected from patients. Information is used to generate accurate invoicing for various third party payers including private insurance providers, automotive insurance providers and workers compensation firms. With your consent reports are provided to your family doctor, your other health providers, third party payers, law firms or other professionals.

We Protect Personal Information

We understand the importance of protecting personal information. For that reason, we have taken the following steps:

- Paper information is either under supervision or secured in a locked or restricted area.
- Electronic hardware is either under supervision or secured in a locked or restricted area at all times. In addition, passwords are used on computers.
- Paper information is transmitted through sealed, addressed envelopes or boxes by reputable companies.
- Electronic information is transmitted either through a direct line or is anonymized or encrypted.
- Staff is trained to collect, use and disclose personal information only as necessary to fulfill their duties and in accordance with our privacy policy.
- External consultants and agencies with access to personal information must enter into privacy agreements with us.

Retention and Destruction of Personal Information

We need to retain personal information for some time to ensure that we can answer any questions you might have about the services provided and for our own accountability to external regulatory bodies. However, we do not want to keep personal information too long in order to protect your privacy.

We keep our client files for about ten years. Our client and contact directories are much more difficult to systematically destroy, so we remove such information when we can if it does not appear that we will be contacting you again. However, if you ask, we will remove such contact information right away. We destroy paper files containing personal information by shredding. We destroy electronic information by deleting it and, when the hardware is discarded, we ensure that the hard drive is physically destroyed.

Please check the boxes below if you are currently experiencing the condition or it has been a significant problem in the past.

General Symptoms

- Headaches
- Sweats
- Fever
- Fainting
- Dizziness
- Clumsiness
- Convulsions
- Loss of sleep
- Loss of weight
- Numbness / tingling
- Loss of strength

Respiratory

- Emphysema
- Asthma
- Bronchitis
- COPD
- Chronic cough
- Chest pain
- Difficulty Breathing

Eyes & Ears

- Blurred vision
- Double vision
- Eye pain
- Earache
- Loss of hearing
- Noise in ears

Nose & Throat

- Frequent colds
- Sinus infection
- Enlarged Glands
- Enlarged Thyroid
- Speech problems
- Trouble swallowing

Genitourinary

- Trouble urinating
- Blood in urine
- Kidney infection
- Prostate trouble

Cardiovascular

- Bleeding disorders
- High blood pressure
- Low blood pressure
- Stroke
- Arterial disease
- Varicose veins
- Poor circulation
- Heart disease
- Blood disease
- Angina

Gastrointestinal

- Poor appetite
- Nausea
- Vomiting
- Ulcer
- Constipation
- Diarrhea
- Pain over stomach
- Diabetes

G.U. for Women

- Menstrual Pain
- Excessive flow
- Hot flashes
- Irregular cycle
- Cramps
- Vaginal Discharge
- Swollen Breasts
- Lumps in Breasts
- Taking birth control
- Pregnancies _____

Neuro/Psychological

- Epilepsy
- Multiple Sclerosis
- Depression
- Anxiety

Other

- HIV / AIDS
- Hepatitis

Please add some detail if you answer **yes** to the following questions:

Do you have any allergies? No | Yes: _____

Do you currently have an infection? No | Yes: _____

Have you ever had any fractures? No | Yes: _____

Have you ever been a smoker? No | Yes: _____

Have you ever been diagnosed with Cancer? No | Yes: _____

Have you ever been in a car accident? No | Yes: _____

Have you ever been Hospitalized? Any Surgeries? No | Yes: _____

Do you take medication on a regular basis? No | Yes: _____