Joint Reaction Health Center
Physiotherapy • Massage
Foot Care

Please note that this document is double sided

Patient Chiropractic Initial Intake Form

Personal Information

Name: _____ Gender: _____

Address:_____ City: _____ Prov:_____

Postal Code:_____ Personal Phone: _____

Birth Date (YYYY/MM/DD) _____/_____/_____ Age:_____ Height _____ Weight _____

Email: _____ (Personal / Work) (circle)
By providing your email, you consent to receive communication from Joint Reaction Health Center/ Dr. Busch in regard to appointment reminders, check-in emails, and exercise programs

Occupation:_____ Time spent @ current job:_____

Marital Status:_____

Extended Health Care Benefits: Y / N Health Insurance Provider:_____
Policy #:_____

Emergency
Contact:_____ Phone Number:_____

Relationship to Emergency Contact: _____

Medical Contact Information

Physician Name: _____ Physician Phone #:_____

Have you attended a chiropractor before? Y / N Name:_____
Did you have a positive experience? Y / N

How did you hear about us? (circle one) Social Media Live in area Personal Referral

If you were referred to Dr. Busch, would you be comfortable in please sharing their name? _____

Have you ever worn orthotics before? Y / N
Are you interested in trying orthotics? Y / N / unsure

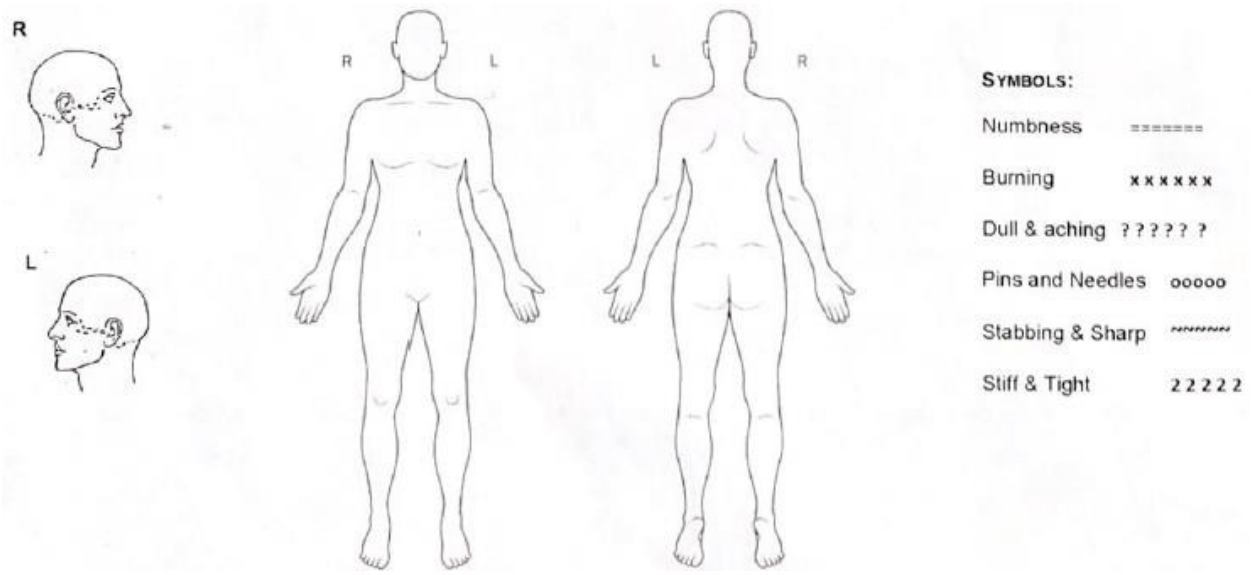
Purpose of Consulting with Chiropractor (Please check one)

- I am interested only in help with my current condition(s), i.e relief
- I am interested in help with my current condition(s) and learning how to correct and prevent it in the future, i.e corrective care
- I have no current problems, but I am interested in optimizing my health through preventative and proactive care
- None of the above. Please explain _____

Confidential Health Screening Questionnaire

The health information requested on the following form will assist us in treating you safely. If you have any questions about the requested information, don't hesitate to ask

In the diagrams provided below, please mark the areas on your body which you feel best represent the pain(s) or sensation(s) you are experiencing. Please include all areas. Use the symbols provided. Please draw a face on the diagram.



What is the main reason for this visit? _____

_____

When did this problem start? _____ How? _____

_____

Has the above-mentioned issue happened before? Y / N When? _____

Have you had imaging for the above issue (ex. X-Ray, Ultrasound, MRI)? Y / N
Do you have access to the imaging report? Y / N

On the scale below, please indicate the intensity of your pain, **when at its worst:**

0 _____5 _____10
(no pain) (moderate) (worst pain imagineable)

Is the problem (circle) Constant Comes & Goes Worse with movement Better with movement

Is the problem (circle) Getting worse Getting better No change

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What movements/activities make your condition **worse**?_____
_____

What things have you tried to make your condition **better**?_____
_____

How would you classify your current activity level? ☐ None ☐ Low ☐ Moderate ☐ High

Are you currently experiencing… (check all that apply)

☐ Increase in pain with coughing/sneezing
☐ Loss/lack of strength
☐ Changes in bowel/bladder frequency/urgency
☐ Increase in body temperature (fever)
☐ Numbness/tingling in arms or legs
☐ Abnormal weight loss of +10lbs in 1 month
☐ Abnormal night sweating
☐ Morning stiffness lasting longer than 30 mins

Are there any other areas of your body not listed above that you would like to be assessed?
_____

Please list any previous accidents, injuries, surgeries, or hospitalizations within the last five years?
1. _____

2. _____

3. _____

Personal and Family History
Please check the pertinent medical conditions as they apply

	Self	**Father's side**	**Mother's side**
Cardiovascular Disease	☐	☐	☐
Stroke	☐	☐	☐
Cancer	☐	☐	☐
Arthritis	☐	☐	☐
Diabetes	☐	☐	☐
High Blood Pressure	☐	☐	☐
Neurological Disease	☐	☐	☐
Osteoporosis/Bone Disorder	☐	☐	☐
Rheumatological Disorder	☐	☐	☐
Other	☐	☐	☐

(Please list) _____

Please list any pertinent/relevant medication/vitamins you are currently taking:

_____

Have you or do you presently smoke?	☐ No	☐ Yes
Any recent changes with your usual sleep pattern?	☐ No	☐ Yes
Do you feel symptoms of anxiety/depression?	☐ No	☐ Yes
Are you currently experiencing symptoms of increased stress?	☐ No	☐ Yes

For female patients:

Do you suspect being pregnant at this time?	☐ No	☐ Yes	☐ N/A

I understand the above Patient Initial Intake Form. I hereby give the Chiropractor my permission to perform a physical examination on the primary and secondary areas of complaint at this time. I understand that the physical examination may elicit discomfort and/or pain. I understand that the physical examination will give the Chiropractor a better understanding of my condition.

Patient Signature: _____

Date: _____

Joint Reaction Health Center
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613-425-8699 Phone
613-425-8633 Fax
www.jointreaction.ca

PHYSIOTHERAPY PRICING

INITIAL ASSESSMENT AND TREATMENT	$115
PHYSIOTHERAPY TREATMENT ONE AREA	$90
PHYSIOTHERAPY TREATMENT 2 AREAS	$105
PHYSIOTHERAPY TREATMENT 3 AREAS	$115

REGISTERED MASSAGE THERAPY PRICING (HST INCL.)

INITIAL ASSESSMENT AND TREATMENT (1HR)	$105
SUBSEQUENT TREATMENT (1HR)	$105
SUBSEQUENT TREATMENT (1/2 HR)	$63
SUBSEQUENT TREATMENT (90 MIN)	$168

CHIROPRACTIC PRICING

INITIAL ASSESSMENT AND TREATMENT	$105
SUBSEQUENT TREATMENT	$60

CANCELLATION POLICY

PLEASE PROVIDE NO LESS THAN **24 HOURS NOTICE** *TO CANCEL ANY APPOINTMENTS TO AVOID BEING SUBJECT TO A* **CANCELLATION FEE** *OF* **$45**, *WHILE A* **NO SHOW** *WILL BE BILLED THE* **FULL FEE.** *THESE FEES WILL BE PAID BY THE CLIENT AND ARE NOT COVERED BY YOUR INSURANCE COMPANY OR WSIB.*
IF YOU DECIDE TO MOVE YOUR APPOINTMENT TO ANOTHER DAY IN THE SAME WEEK, LESS THAN 24HRS PRIOR TO YOUR APPOINTMENT, YOU MUST ATTEND THE SAME AMOUNT OF APPOINTMENTS SCHEDULED FOR THAT WEEK. OTHERWISE YOU ARE SUBJECTED TO THE CANCELATION FEE. *FAILURE TO RESPOND TO NOTIFICATION OF THESE FEES WILL RESULT IN* **THE ACCOUNT** *BEING SENT TO A COLLECTION AGENCY. FAILURE TO PAY THE FEES WILL RESULT IN* **THE ACCOUNT** *BEING SENT TO A COLLECTION AGENCY.*

I have read and agree to the terms of the cancellation policy. Initials: _____

CONFIDENTIALITY

All records are confidential. Release of medical information to a third party (i.e. work lawyer, insurance company) will be subject to your approval. Progress reports and Discharge reports will be forwarded to a family/referring physician. All client information sent is passed through our Health Information Custodian (HIC) Scott Mooney. Any questions regarding privacy may be directed to scott@jointreaction.ca.

CONSENT TO ABOVE POLICIES AND CONDITIONS

I, the undersigned, have read and understand the above stated and consent to the terms of the cancellation policy. I give permission to Joint Reaction Health Center to assess, treat and educate me with a therapeutic program that is best suited for my condition. Risks cannot be completely eliminated but all precautions will be made to minimize them, including but not limited to COVID-19.

Name: _____ Date: _____
Please Print

Signature: _____ Parent/Guardian: _____
(Child is Patient)