



Muscle & Joint Clinic

First Name: _____ Last Name: _____

Email: _____ Phone Number: _____

Address: _____ City: _____

Postal Code: _____ Age: _____ Date Of Birth: (dd) _____ (mm) _____ (yyyy) _____

Height: _____ Weight: _____ Gender: _____

Occupation: _____

Family Physician's Name: _____

Family Physician's Address: _____

How did you hear about us? _____

Do you have health insurance: Yes No Does your spouse have health insurance? Yes No

Spouse's Date Of Birth: (dd) _____ (mm) _____ (yyyy) _____

<input type="radio"/> Great West Life	<input type="radio"/> GreenShield	<input type="radio"/> Standard Life	<input type="radio"/> Claim Secure
<input type="radio"/> Sunlife	<input type="radio"/> Desjardins	<input type="radio"/> Equitable Life	<input type="radio"/> Other
<input type="radio"/> Blue Cross	<input type="radio"/> Industrial Alliance	<input type="radio"/> Manulife	Policy: _____ ID _____

Clinic Fees			
First Consultation (15 mins)	Free	Follow Up Visit	\$55
Extended Consultation (30 mins)	\$95	Re Exam	\$75
First Treatment	\$95	X-Ray Fee	\$25

- All fees are due at time of service and it is the patient's or guardian's responsibility to ensure the clinic is fully compensated for all services rendered.
- A 48 hour cancellation policy is in effect. Failure to show up for a scheduled appointment or arriving 30 minutes late will result in a no show fee of half of the visit fee, and will be added to the patient's account.
- Accounts over thirty days may be subject to collections and a twenty-five percent service fee of the balance owing
- All insurance related information collected by our clinic cannot be guaranteed to be accurate. Please contact your insurance company directly for accurate information in regards to your insurance plan.
- If you have read and agree to the clinic fees and policies above please sign below:

Sign Here: _____

Please highlight on the image where your pain is located:

When did this pain begin?

Was this pain from a:

- Work Injury
- Auto Accident

Is this pain getting:

- Better
- Worse

Does this pain occur:

- All Day
- Comes & Goes

Do you experience pain when you cough? Yes No

What is the quality of pain? Sharp Dull Achy Stabbing Shooting

Severity of pain (circle one): 0 (no pain) 1 2 3 4 5 6 7 8 9 10 (severe)

When is the pain better? Morning Afternoon Evening Night All Day

When is the pain worse? Morning Afternoon Evening Night All Day

Does the pain travel to any other parts of the body? Yes No

Are you experiencing numbness or tingling sensations? Yes No

What makes the pain better?

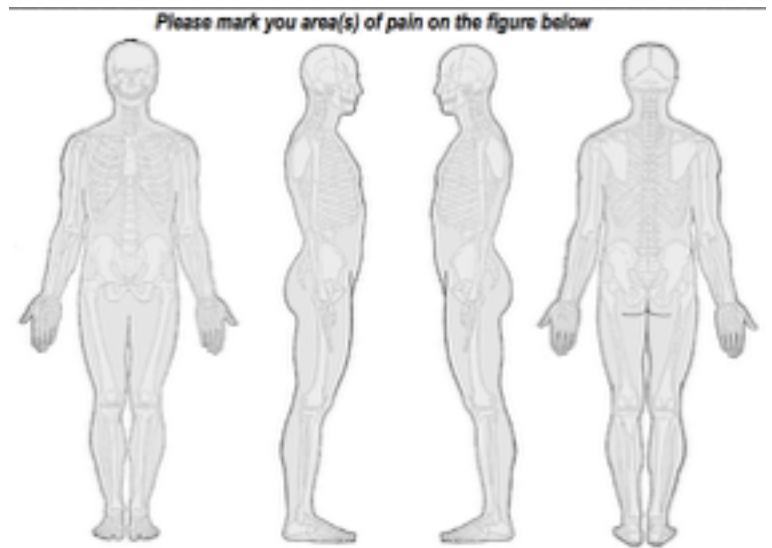
What makes the pain worse?

Who have you seen for this condition:

- Family Doctor
- Chiropractor
- Massage Therapist
- Physiotherapist
- Acupuncturist
- Chiropodist
- Specialist
- Other _____

Do you or your immediate family have any of the following conditions?

- Cancer
- Diabetes
- Heart Disease
- Arthritis
- Osteoporosis
- High BP
- Stroke



- Are you on any medication? Yes No
- Have you been diagnosed with any medical conditions? Yes No
- Have you had any surgeries? Yes No
- Have you fractured or dislocated any bones? Yes No
- Have you had a physical exam over the past 12 months? Yes No
- Have you been in an auto accident in the past 2 years Yes No
- Have you been admitted to a hospital before? Yes No
- Have you had any major slips or falls? Yes No
- Are you experiencing any muscle weakness? Yes No
- Have you experienced any abnormal gain or loss in weight recently? Yes No
- Does the pain wake you up at night? Yes No
- Are you experiencing night sweats? Yes No
- Are you experiencing any swelling? Yes No
- Has the pain prevented you from working? Yes No
- Have you had this condition previously? Yes No
- Do you play any contact sports (football, hockey) Yes No
- Do you have a family history of this condition? Yes No
- Have you had x-rays in the past five years? Yes No
- Have you had an MRI in the past five years? Yes No
- Have you been prescribed orthotics? Yes No
- Are you a smoker? Yes No
- Are you physically active? Yes No
- (Women Only) Are you pregnant? Yes No

Doctor Notes:

Please rate your average stress level:

- 0 (no stress) 1 2 3 4 5 6 7 8 9 10 (severe stress)

To what extent has this condition affected your daily life:

- 0 (none) 1 2 3 4 5 6 7 8 9 10 (severely)

How motivated are you towards treatment of your pain condition

- 0 (not motivated) 1 2 3 4 5 6 7 8 9 10 (considerably)

Thank you, We Will Be With You Shortly!

YOUR PRIVACY IS OUR PRIORITY

Patient Consent Form For Collection, Use and Disclosure of Personal Information

In this office, for their respective patients, Dr. Faisal Malik acts as the Privacy Information Officer. All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate use and protection of your information. Attached to this consent form, we have outlined what our office is doing to ensure that: Only necessary information is collected about you; Information is shared only with your consent; Storage, retention and destruction of your personal information complies with existing legislation, and privacy protection protocols; Our privacy protocols comply not only with privacy legislation, but with the standards of the Ontario Chiropractic Association, and the law. Do not hesitate to discuss our policies with Dr. Faisal Malik or any member of our office staff. Please be assured that every staff member in our office is committed to ensuring that you receive the best quality health care. This office will collect, use and disclose information about you for the following purposes: To offer and provide treatment, care and services for all chiropractic health care issues. To deliver safe and efficient patient health care and to identify and ensure continuous high quality service. To assess your health care needs and to advise you of treatment options. To enable us to contact you and maintain communication with you, for purposes of distributing health care information and booking/confirming appointments for treatments. To maintain communication with you through email newsletters. To invoice for goods and services, to process credit card payments, and to collect on unpaid accounts. To communicate with other treating health care providers, including your pharmacist/pharmacy. To communicate with laboratories in cases where laboratory services are required. For teaching and demonstrating purposes on an anonymous basis. To complete and submit chiropractic claims for third party adjudication and payment. To comply with legal and regulatory requirements, including the delivery of patients' charts and records to the Ontario Chiropractic Association in a timely fashion, when required, according to the provisions of the **Personal Health Information Protection Act (PHIPA)** . To comply with agreements/undertakings entered into voluntarily by the member with the Ontario Chiropractic Association, including the delivery and/or review of patients' charts and records to the Association in a timely fashion for regulatory and monitoring purposes. To deliver your charts and records to the Chiropractic insurance carrier to enable the insurance company to assess liability and quantify damages, if any. To assist this office to comply with all regulatory requirements and to comply generally with the law By signing the consent section of the Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information for the purposes that are listed. If a new purpose arises for the use and/or disclosure of your personal information, we will seek your approval in advance. Your information may be accessed by regulatory authorities under the terms of the **Personal Health Information Protection Act (PHIPA)** for the purposes of the Ontario Chiropractic Association fulfilling its mandate under the PHIPA, and for the defence of a legal issue. Our office will not, under any condition, supply your insurer with your confidential medical history. In the event that this kind of a request is made, we will forward the information directly to you for review, and for your specific consent. When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate. You may withdraw your consent for use or disclosure of your personal information at any time, and we will explain the ramifications of the decision, and the process.

Patient Consent

I have reviewed the Privacy Policy that explains how this office will use my personal information, and the steps this office is taking to protect my information. I know that this office has a Privacy Policy, and I can ask to see the Policy at any time. I agree that Dr. Faisal Malik and his staff can collect, use and disclose personal information about myself as set out in the attached information about the office's privacy policies.

Signature: _____ **Date (dd/mm/yy):** _____/_____/_____