Muscle & Joint Clinic

First Name: _____ **Last Name:** _____

Date of Birth (dd/mm/yy) _____/_____/_____ Age: _____ Height: _____ Weight: _____ Gender: ☐ M ☐ F

Address: _____ City: _____

Postal Code: _____ Home Ph: _____ Cell : _____

Email: _____ How Did You Hear About Us? _____

Family Doctor's Full Name _____

Family Doctor's Address: _____

Do you have extended health insurance? ☐ Yes ☐ No Occupation: _____

Does your spouse have extended health insurance? ☐ Yes ☐ No If Yes, spouse's date of birth: _____

☐ Great West Life
☐ Sunlife
☐ Blue Cross
☐ Green Shield
☐ Desjardins
☐ Industrial Alliance
☐ Standard Life
☐ Equitable Life
☐ Claim Secure
☐ Manulife
☐ Other

Policy Number: _____

Group ID: _____

Consultation (10 min)..... Free	X-Ray Reading Fee.....$25
Examination Fee.....$85	Documentation/FAF Forms .....$20 pp
Treatment.....$55	Late or No Show Fee.....$25
Reassessment.....$65	Orthotics .....$450 to $700

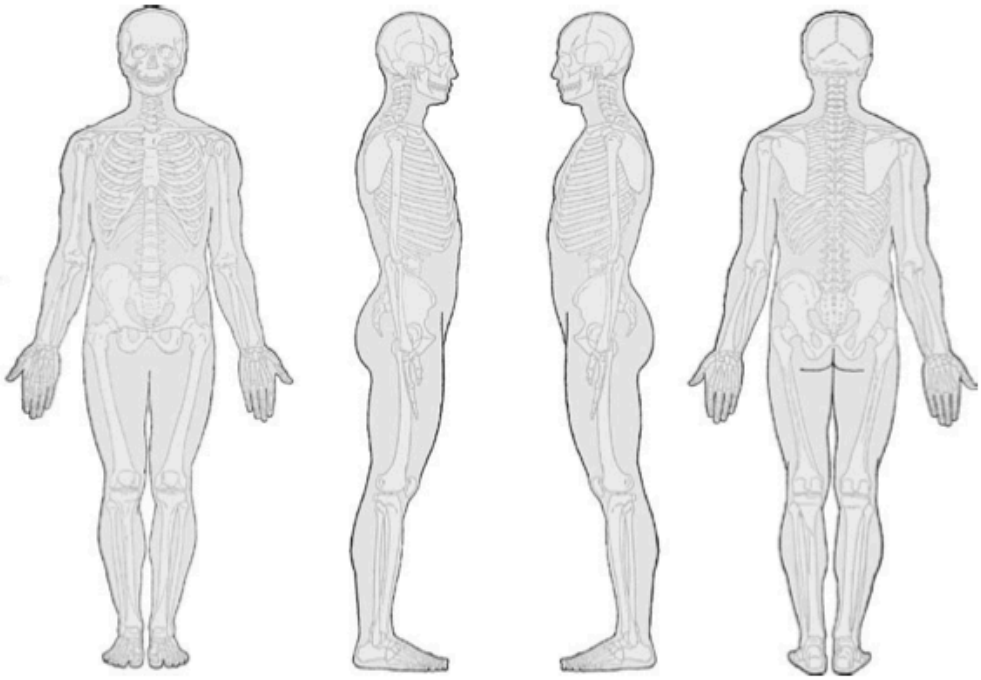
- All fees are due at time of service and It is the patient's or guardian's responsibility to ensure the clinic is fully compensated for all services rendered.
- A 48-hour cancellation policy is in effect. Failure to show up for a scheduled appointment or arriving 30-minutes late will result in a no show fee of half of the visit fee will be added to the patient's account.
- Accounts over ninety days may be subject to collections and a twenty-five percent service fee.
- All insurance related information collected by our clinic can not be guaranteed to be accurate. Please contract your insurance company directly for accurate information in regards to your insurance plan.
- If your care is the result of a work injury or auto injury, the patient is still responsible for all outstanding fees owing to the clinic for services rendered.

If you have read and agree to the clinic fees and policies above please sign below:

Dr Faisal Malik - Chiropractor Lic# 5849

4-5980 Churchill Meadows Blvd, Unit 4, Mississauga, L5M 7M5

Please mark you area(s) of pain on the figure below



Where is your pain located? _____

When did this pain begin (Specific date if possible): _____

Was this pain a result of a: ☐ Work Injury ☐ Car Accident ☐ Other: _____

Is the pain getting better or worse? ☐ Better ☐ Worse ☐ Staying the same

Does the pain occur: ☐ All Day ☐ Comes & Goes ☐ Other

Do you experience pain when you cough? ☐ Yes ☐ No

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

Severity of pain: ☐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 If yes where? _____

Are you experiencing numbness or tingling sensations? ☐ Yes ☐ No If yes where? _____

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_____

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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 (none) .....5.....10 (considerably)

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

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

To what extent has this condition affected your daily life: _____

0 (none) .....5.....10 (considerably)

How motivated are you towards treatment of your pain condition: _____

0 (none) .....5.....10 (considerably)

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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 defense 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): _____/_____ /_____

Doctors Notes

Review intake questionnaire ('CI's'or 'red flags'?)

- Why are they seeking care today?

Chief concern

1. Location/radiation

- Where does it hurt? (point to it)
- Does the pain move anywhere? if so where?

2. Onset (when/how)

- When did it start? (gradual or sudden)
- What is the cause of chief concern?

3. Chronology/timing/prior episodes

- Have they had anything like this before?
- Clarify: Constant? Episodic? Occasional?
- How many times a day/week/month?

4. Quality (sharp, dull, shooting)

- Describe the pain with a word or two?
- Is it getting worse or better?

5. Severity (0-10)/effect on ADLs

- On a scale of 0-10 rate your pain (10 being the worst pain imaginable)?
- What is it at its worst? at its best?
- Does it affect any of your daily activities? (be specific)

6. Modifying factors (better/worse)

- What makes it feel better?
- What makes it feel worse?

7. Associated symptoms (NTW)

- Do they have any numbness, tingling or weakness?
- Any other symptoms associated with chief concern?

8. Treatment history/relevant prior injuries

- Have they seen anyone else about chief concern?
- If yes, then who (specific) & what treatment were given? Did they work?
- Any relevant prior injuries (when/treatment given)?

9. Medications/Allergies (purpose, dose, frequency)

Conditional factors

1. Hereditary conditions/family health issues

- Do any conditions run in family?

2. Stress factors

- What are their main life stress factors?

3. Exercise/interests (activities/frequency)

4. Diet (rate: good, fair, poor)

5. Sleep pattern (wake rested)

6. Habits (alcohol, tobacco, recreational drugs)

7. Treatment goal (this treatment & long term)

"Is there anything else relevant that they would like to add?"

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