TOTEM WELLNESS

Patient Intake Form

Date: _____

Name: _____

Date Of Birth: Y Y Y Y / M M / D D Height:_____ Weight:_____

Address:_____

City: _____ Province: ____ Postal Code: _____

Home Telephone: _____ Cell/Bus. Telephone: _____

Email Address:_____

Family Doctor: _____ Address: _____

Telephone: _____

Emergency Contact:_____Telephone:_____

Who may we thank for your referral?_____

Main Sports/ Activities: _____

Occupation: _____

Goals
Name 3 Goals that you have for our treatments:

1. _____
2. _____
3. _____

Appointment Billing

We accept payments in the form of credit card (Visa, M/C, Amex), Interact, cheque or cash.

As a new patient, we require an active credit card to reserve your appointment times to be kept on file for cancellation purposes. For your convenience, Totem Wellness can store your preferred credit card on file to process payments automatically. Rates are on the back page.

Please note that rates may apply for additional forms of communication via phone or email.

Credit Card # _____ Expiry Date: _____

□ I wish to use this card on file to be processed automatically the day of my appointment.

FOR OFFICE USE ONLY

Date of Initial Health History: _____

Update 1:_____

Update 2:_____

Update 3:_____

TOTEM WELLNESS

Name:_____
DOB:_____

Health History

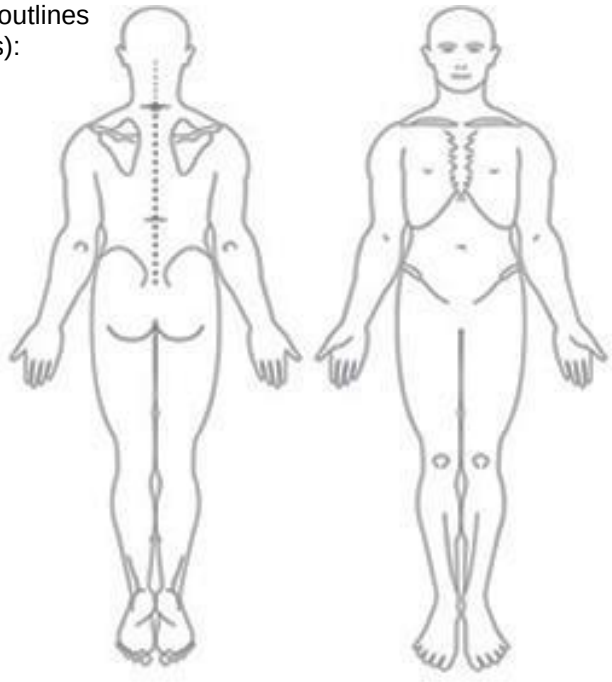
In order to ensure safe and optimum care, your therapist requires the following information. This information will be kept strictly confidential.

How often do you exercise a week? None 1x 2x 3x 4x 5 or more times

Rate your pain on a scale from 1 to 10 (where 1 = mild, 10 = worse pain)

Use the following descriptive symbols on the body outlines to describe the location of your primary complaint(s):

Ache = A
Burning = B
Numbness = O
Pins & Needles = I
Sharp/Stabbing = S
Other = X



Have you had any unexplained weight loss in the last month?	Yes	No
Do you wear orthotics or special shoe or ski boot inserts?	Yes	No
Are you currently or have you previously received any of the following treatments (chiropractic, acupuncture, radiation, chemotherapy, massage therapy, physiotherapy)?	Yes	No

If yes, list when and where:_____

TOTEM WELLNESS

Name:_____
DOB:_____

Past Medical History:
Overall, how would you describe your general health? _____

Do you suffer from or have you ever been told you have the following issues, conditions and/or disease? (Please check all that apply - for family history please specify 'F').

RESPIRATORY	Y	N
Chronic cough		
Shortness of breath		
Bronchitis		
Asthma		
Emphysema		

CARDIOVASCULAR	Y	N
High BP		
Low BP		
Irregular heart rate		
Chronic congestive heart failure		
Angina/chest pain		
Heart disease		
Heart attacks		
Pacemaker		
Stroke/CVA		
Phlebitis		
Blood Clots		
Circulation		

WOMEN	Y	N
Pregnant		
Due:		
Menses (#of days)		
-Complaints:		
Issues:		
-Specify:		

HEAD/NECK	Y	N
Headaches/Migraines		
Neck pain/stiffness		
Ear problems		
Hearing loss		
Vision problems/loss		
Concussion		
- Loss of consciousness		
Dizziness		

MUSCULOSKELETAL	Y	N
Neck/upper back		
Lower back		
Shoulder		
Arms		
Legs		
Knees		
Other:		

INFECTIONS	Y	N
HIV		
Tuberculosis		
Skin conditions		
Specify:		
Hepatitis		
Herpes		
Other:		

OTHER CONDITIONS	Y	N
Arthritis		
Allergies		
Bowel/bladder		
Cancer		
Circulation problems		
Diabetes		
Digestive conditions		
Epilepsy		
Haemophilia or slow healing		
Mental illness		
Nausea/vomiting		
Osteoporosis		
Pain in arms or legs		
Sciatica		
Sensation loss/numbness		
Specify:		
Skin conditions		
Thyroid condition		
Trouble swallowing		
Trouble with speech		
Hypersensitivities:		
- Medications		
- Tape		
- Cold		
- Latex		
History of Frostbite:		

Have you had any of the following tests done recently? (Please circle all that apply)

X-Ray CT Scan MRI EMG Bone Scan Blood Work Urinalysis Ultrasound

Please state when and where:

_____

Current Medication(s): (Prescriptions, Over the Counter, Supplements)

TOTEM WELLNESS

Name:_____
DOB:_____

_____

_____

_____

Previous Anesthetic/Surgeries: Yes No

Date: _____Type:_____
Outcome: _____

Date: _____ Type: _____
Outcome:_____

Do you have any internal pins, wires, artificial joints or special equipment? Yes No

Please specify: _____

Previous Injuries: Yes No

Date: _____ Type: _____
Outcome:_____

Date: _____ Type: _____
Outcome:_____

Signed by client: _____

Therapist:_____ Oren Smith, Physiotherapist #11534
OR Erin Smith, Athletic Therapist #21546

Cancellation Policy

Totem Wellness offers same day bookings, as well as emergency bookings. Because of this, it is imperative that our schedule is kept up to date. If you need to cancel or rebook your appointment, changes may be made up to 24 hours prior to your scheduled appointment time; otherwise you will be charged the full amount of the appointment. We require all patients to keep an up to date credit card on file to be processed in the event of a missed appointment.

By signing below I acknowledge Totem Wellness's 24 hour cancellation policy and consent to discussed treatment plan, and assure that all medical information provided is accurate to the best of my knowledge.

Signature: _____
For Office Use;

I understand that I am booking for a consultation, assessment, treatment, and home program with Totem Wellness Inc. I am signing that I have been educated about the issues discussed and am giving Informed Consent for treatment to continue.

Signature: _____**Therapist:**_____

TOTEM WELLNESS

Name:_____
DOB:_____

Rates

Physiotherapy	Oren Smith	1 hour	$200	HST exempt
		90 minute	$300	HST exempt
		2 hour	$400	HST exempt
Athletic Therapy	Erin Smith	1 hour	$200	including HST
		90 minutes	$300	including HST
		2 hour	$400	including HST
Holistic Lifestyle Coaching				
	Erin Smith	1 hour	$200	including HST
		90 minutes	$300	including HST
		2 hour	$400	including HST
Holistic Health & Wellness Coaching				
	Oren Smith	1 hour	$200	including HST
		90 minutes	$300	including HST
		2 hour	$400	including HST

Custom Made Orthotics	$500	HST exempt
Orthotics Modifications	$75	HST exempt
Off the shelf bracing	$specific by brace	
Custom made bracing	$specific by brace	

Please note;
Some of our services may not be covered by SunLife, Manulife and Equitable Life of Canada Insurance Companies.