Momentum Health Patient Intake Form

NAME:____ DATE: _______________________

DATE OF BIRTH: MMM / DD / YYYY AGE: _____ BC HEALTH CARE #:____________________

ADDRESS:____ POSTAL CODE:____________________

CITY:_______________________ PHONE: _____________________

EMAIL:____May we contact you by email? YES or NO

Would you like to be set up for appointment reminders? YES - Email / Text / Both or NO Reminders

OCCUPATION: ______________________________

Emergency contact:______________________________________Phone: _________________________

HOW DID YOU HEAR ABOUT OUR CLINIC? (please circle one)
Website Doctor (name:__________________________Patient/Friend (name:________________________) Walk-in
Other: ____

Do we have your permission to contact your family physician regarding coordination of your care? YES or NO
If yes, what is your family doctors name and location of practice? ______________________________________

PLEASE NOTE OUR LATE CANCELLATION/MISSED APPOINTMENT POLICY:
Momentum Health is committed to providing all of our patients with exceptional and timely care. We would appreciate 24 hours advance notice if you are unable to attend a scheduled appointment so we can attempt to fill the appointment time. Failure to do so may result in a **missed appointment charge up to 100% of the cost of your appointment** payable prior to your next appointment being administered to your account. I have read and agree to the above terms:_____**(Initial)**

Is the reason you came to this office related to a:

A) Motor Vehicle Accident? YES NO **Date of loss:** MM / DD / YYYY
B) Work-related injury (WCB)? YES NO **Date of loss:** MM / DD / YYYY

When did your symptoms start? ____

Describe your symptoms and when they began: ____

____

How often do you experience your symptoms?

- Constantly (76 - 100% of the day)
- Frequently (51 - 75% of the day)
- Occasionally (26 - 50% of the day)
- Intermittently (0 - 25% of the day)

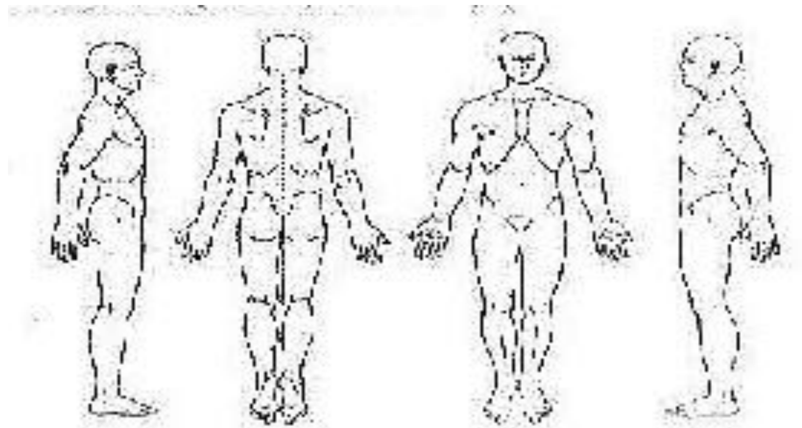
What describes the nature of your symptoms?

- Sharp
- Dull ache
- Numb
- Shooting
- Burning
- Tingling

How are your symptoms changing?

- Getting better
- Not changing
- Getting worse

Indicate where you have pain or other symptoms:



How would you currently rate your symptoms?

none 0 1 2 3 4 5 6 7 8 9 10 *unbearable*

How do your symptoms affect your ability to perform daily activities?

0	1	2	3	4	5	6	7	8	9	10
no complaints			*mild, forgotten with activity*		*moderate, interferes with activity*		*limiting, prevents full activity*	*intense, preoccupied with seeking relief*		*severe, no activity possible*

Who have you seen for your current symptoms? ☐ No one ☐ Medical Doctor ☐ Other ☐ Chiropractor ☐ Acupuncturist ☐ Massage Therapist

What activities make your symptoms worse? ____________________

What activities make your symptoms better? ____________________

What tests have you had for your symptoms and when were they performed?

☐ X-Ray: (date) ☐ MRI : (date) ☐ CT Scan: (date) ☐ Other: (date)

What type of regular exercise do you perform? ____________________

How has your sleep been? Before condition (Excellent/Good/Poor) **Since condition started?** (Excellent/Good/Poor)

For each of the conditions listed below, place a check in the *"Past"* column if you have had the condition in the past. If you presently have a condition listed below, place a check in the *"Present"* column.

Past	Present		Past	Present		Past	Present	
☐	☐	Headaches	☐	☐	High Blood Pressure	☐	☐	Diabetes
☐	☐	Neck Pain	☐	☐	Heart Attack	☐	☐	Excessive Thirst
☐	☐	Upper Back Pain	☐	☐	Chest Pains	☐	☐	Frequent Urination
☐	☐	Mid Back Pain	☐	☐	Stroke			
☐	☐	Low Back Pain	☐	☐	Angina	☐	☐	Smoking/use of tobacco products
☐	☐	Shoulder Pain	☐	☐	Kidney Stones	☐	☐	Allergies
☐	☐	Elbow/Upper Arm Pain	☐	☐	Kidney Disorders	☐	☐	Depression
☐	☐	Wrist Pain	☐	☐	Bladder Infection	☐	☐	Systemic Lupus
☐	☐	Hand Pain	☐	☐	Painful Urination	☐	☐	Epilepsy
			☐	☐	Loss of Bladder Control	☐	☐	Dermatitis/Eczema/Rash
☐	☐	Hip/Upper Leg Pain	☐	☐	Prostate Problems	☐	☐	HIV/AIDS
☐	☐	Knee/Lower Leg Pain						
☐	☐	Ankle/Foot Pain	☐	☐	Abnormal Weight Gain/Loss			
			☐	☐	Loss of Appetite			**Females Only:**
☐	☐	Jaw Pain	☐	☐	Abdominal Pain			
			☐	☐	Ulcer	☐	☐	Birth Control

☐	☐	Joint Swelling/ Stiffness	☐	☐	Hepatitis	☐	☐	Hormonal Replacement
☐	☐	Arthritis	☐	☐	Liver/Gall Bladder Disorder	☐	☐	Pregnancy
☐	☐	Rheumatoid Arthritis						
			☐	☐	Cancer			
☐	☐	General Fatigue	☐	☐	Tumor			
☐	☐	Dizziness	☐	☐	Asthma			
☐	☐	Visual Disturbances	☐	☐	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

☐ Rheumatoid Arthritis ☐ Heart Problems ☐ Diabetes ☐ Cancer ☐ Lupus ☐ Other:

List all prescriptions and over-the-counter medications and nutritional/herbal supplements you are taking:

____

List all the surgical procedures and hospitalizations:

____