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Patient Intake Form

Please print clearly. If you have any questions, please ask our staff. Thank you.

PERSONAL INFORMATION

Name
First Name Middle Initial Last Name

Address

City Province Postal Code

Phone numbers:
Home: Business:

Cell Phone #: Email:
I consent to appointment reminders via text: Yes ☐ No ☐ I consent to receiving emails from Lifemark Yes ☐ No ☐

Date of Birth / / ☐ Female ☐ Male ☐ Other
Day Month Year

Date of Injury (D/M/Y) or gradual onset ☐ Area of Injury

Employer/School: Occupation:

Health Card # _____ Version code (ON) _____ Province: _____

For ON/AB: Are you on a Provincially funded Support Program or qualify as low income? Yes ☐ No ☐

If Yes, please provide name of program, case worker name and phone number:

Is your injury funded by: ☐ MVA ☐ WCB/WSIB/CSST ☐ LTD ☐ RCMP ☐ DND ☐ DVA

Claim Number or Member ID: Policy No:
Policy holder Name:

Employer at time of injury: ☐ same as above

Adjustor/Case Workers' Name:

For ON/AB/NS MVA claims: Have you completed your Accident benefits package (OCF-1/AB1/NS1) Yes ☐ No ☐

Extended Health Care Insurance Coverage: ☐ Yes ☐ No If Yes, please complete below:

Primary Company Name:	Secondary Company Name:
Policy/Plan No:	Policy/Plan No:
Certificate/ID No:	Certificate/ID No:
Policy holder name:	Policy holder name:
Policy holder date of birth (D/M/Y):	Policy holder date of birth (D/M/Y):

Who can we thank for your referral?

Name: Address:

What most influenced your decision to choose Lifemark?

☐ Family Doctor	☐ Returning Patient / Self	☐ Yellow Pages	☐ Blue Nose Marathon
☐ Medical Specialist	☐ Rehab Consultant	☐ Radio / TV	☐ Trade show / Health Fair
☐ Walk-in Clinic	☐ Facebook	☐ Signage / Location	☐ Internal referral
☐ Employer	☐ Google listing / Review	☐ Internet	☐ Dentist
☐ Insurance Co.	☐ Coach / Teacher	☐ Government	☐ OpenCare
☐ WCB/WSIB	☐ Lawyer	☐ Other (specify)	
☐ Friend / Relative	☐ Print Advertising	_____	

ON Use only:

Photo ID verified: Y/N **HC Expiry:**_____ **Staff Initials:**_____ **Date:**_____

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Patient Intake Form

Physicians

Family Physician: Phone:

Referring Physician: Phone:

☐ Same as Family Physician

☐ Emergency Contact or ☐ Guardian (for Patients under the age of 18)

Name:

Relationship to Patient: Phone:

Payment Information

I understand that payment for services received at the clinic is my responsibility. If my treatment services are to be submitted directly to an outside agency for payment, and for some reason the third-party payer, such as WCB/WSIB, insurance or employer, denies the claim and/or refuses to pay all or any of the full amount billed, I am responsible for paying the amount outstanding.

I acknowledge if appropriate cancellation notice is not provided I may be charged a cancellation fee up to the full cost of the appointment. I also acknowledge that third party funders may not pay for cancellation charges, and that I will be personally responsible for applicable fees.

_____ _____

Signed (If the patient is under the age of 18, a guardian must sign for them) Date

_____ _____

Witness Date

EXPRESS CHECKOUT

To facilitate your billing and payment process, we can conveniently bill your credit card. You will be billed daily / weekly / semi-monthly (circle preference).

This frees you from standing in line at reception to settle your account after each treatment. Invoices will be prepared for you when payment is processed. These invoices can be submitted to your extended health care insurance company for reimbursement.

For security purposes, your credit card information will be completely removed from our records upon your Discharge.

Please sign consent below for our express check out option.

Signature: _____ Date: _____

Witness: _____ Date: _____

Patient Health History Form

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The information requested below will enable us to treat you safely. If you have any questions about the information requested please ask your health care professional (HCP). All information provided below will be kept confidential. Your written permission is required to release any information.

HCP ❑ **Occupational Therapist** ❑ **Physiotherapist** ❑ **Kinesiologist** ❑ Massage Therapist

Patient Name: _____

Occupation: _____ **Have you received therapy before?** ❑ **Yes** ❑ **No**

If yes, who referred you for therapy? _____

What is your reason for seeking therapy? _____

Cardiovascular

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chronic congestive heart failure
- ❑ Heart attack
- ❑ Phlebitis/ varicose veins
- ❑ Stroke/ CVA
- ❑ Pacemaker or similar device
- ❑ Heart disease

Is there a family history of any of the above conditions? Yes / No

Respiratory

- ❑ Chronic cough
- ❑ Shortness of breath / Chest pains
- ❑ Bronchitis
- ❑ Asthma
- ❑ Emphysema

Is there a family history of any of the above conditions? Yes / No

Do you smoke? Yes / No

Infections

- ❑ Hepatitis
- ❑ Skin conditions (acne, athletes foot)
- ❑ TB
- ❑ HIV
- ❑ Herpes

Other Conditions

- ❑ Cancer (where)
- ❑ Diabetes, type and onset
- ❑ Thyroid disorder
- ❑ Allergies / hypersensitivity to what? _____
- ❑ Epilepsy
- ❑ Arthritis
- ❑ Osteoporosis
- ❑ Mental illness
- ❑ Hemophilia
- ❑ Do you have any internal pins, plates or artificial joints?
- ❑ Do you have any artificial limbs?
- ❑ Loss of sensation? Where?
- ❑ Nervous system disorder: Type: _____
- ❑ Sleep disorders

Head/ Neck

History of Headaches: type & frequency:

- ❑ History of migraines
- ❑ Vision problems
- ❑ Vision loss
- ❑ Ear problems
- ❑ Hearing loss
- ❑ Head trauma

Women

- ❑ Pregnant, due date:
- ❑ Gynaecological conditions: What? _____
- ❑ Menstrual problems
- ❑ Diseases of the breasts,
- ❑ Uterus or ovaries

Digestive

- ❑ Ulcer ❑ Hernia
- ❑ Gall bladder/ liver
- ❑ Kidney / bladder
- ❑ Constipation/ diarrhea
- ❑ Painful/ frequent urination

Do you suffer from any digestive conditions? What are they?

_____

Muscles / Joints

Previous pain / stiffness

- ❑ TMJ
- ❑ Neck
- ❑ Low back
- ❑ Mid back
- ❑ Upper back
- ❑ Hip L/ R
- ❑ Knee L/ R
- ❑ Ankle L/ R
- ❑ Shoulder L / R
- ❑ Elbow L /R
- ❑ Wrist L/ R
- ❑ Hand L/ R
- ❑ Other:

List all medications you are taking and the conditions they are for: _____

_____

List any surgeries you have had. Please include types and dates: _____

_____

List any past injuries. Please include types and dates: _____

_____

Please list any other Health care professional you are currently receiving treatment from: _____

_____

**** If you would like to provide additional information, please turn sheet over and use the blank side.**

_____ _____

Signature Date

For internal use only

Date of initial health history:

Update 1:

Update 2:

Update 3:

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CONSENT FOR COLLECTION, USE AND RELEASE OF PERSONAL INFORMATION

CONSENT TO RELEASE INFORMATION

I, _____ give Lifemark my consent to release information to, and to obtain information from the following individuals with respect to my care by report, letter, phone, fax, email or direct communication:

Physician(s): _____

Insurer(s): _____

Employer: _____

Other, specify: _____

Patient Signature: _____ **Date:** _____

USES OF PERSONAL INFORMATION

Lifemark collects, uses, discloses, retains and disposes of your personal information in compliance with federal and provincial privacy legislation and applicable college regulations. All staff members who come in contact with your personal information have signed a confidentiality form and have been trained in the appropriate use and protection of your information. If you have any questions, please contact the Lifemark Privacy Officer at 1-866-446-3080 or via email at privacyofficer@lifemark.ca.

We may use and disclose your personal information to:

- Establish your rehabilitation needs,
- Address specific questions related to your entitlement to benefits under a private insurance plan,
- Obtain payment for our services from your private insurer or others,
- Send written notices or contact you to advise of upcoming appointments,
- Provide a written report to the party that requested the service,
- Plan, administer and manage our internal operations,
- Compile statistics.

Your Choices

You may access and correct your personal health records, or withdraw your consent for some of the above uses and disclosures (subject to legal exceptions) by contacting us in writing. A fee may be charged to access your personal health records.

Important Information

We take steps to protect your personal health information from theft, loss and unauthorized access, copying, modification, use, disclosure and disposal.

We take steps to ensure that everyone who performs services for us protects your privacy and only uses your personal health information for the purposes you have consented to.

Patient Signature: _____ **Date:** _____