

CONFIDENTIAL PATIENT INFORMATION FORM

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| PATIENT DETAILS |
| Title (circle):Mr. Mrs. Ms. Miss Dr. | Last name: | First name: | Middle Initial (s): |
| How would you like to be addressed? (e.g. first name, last name, nick-name): |
| Sex: M F  | Birthdate (M/D/Y): | Age: | Care card #: | Occupation: |
| Current mailing address (including postal code): |
| Home phone number: | Cell phone number: | Work phone number: | Email address: |
| Would you like to receive appointment reminders and clinic updates via email? Yes NoWould you like to receive cell phone appointment reminder via text message? Yes NoPlease tell us when you wish to have your reminder (circle): 2 days before your appointment 2 hours before your appointment |
| Emergency contact name: Phone number: Relationship (e.g. friend/spouse): |
| Primary practitioner/doctor’s name: Phone number(if known): Have you seen a medical doctor for this complaint? Yes No |
| How did you hear about Kamloops Integrated Wellness? (circle): Internet Yellow Pages Flyer WorkshopHealthcare professional (name):Friend/personal referral (name):  |
| Is this an ICBC claim? Yes NoDate of accident: Claim #:  | Is this a WCB/workplace injury? Yes NoDate of accident: Claim #: |
| If this is an ICBC or WCB claim please for the receptionist now |
| KAMLOOPS INTEGRATED WELLNESS POLICIES AGREEMENT |
| Payments: Payments is due at the beginning of each treatment. If any secondary party should deny payment (WCB, RCMP, ICBC) full cost of the treatment will be passed on to the patient. Any cancellation fees are the responsibility of the patient. INITIALS: Cancellations/missed appointments: To respect our practitioners time we ask for 24-hours notice to cancel or reschedule your appointments. If you miss or cancel with less than 24-hours notice you will be responsible for the full cost of your appointment. INITIALS: Privacy: I Authorize KIW to collect my personal & medical information and to contact me via email, text or phone via the information provided. I authorize KIW to contact my MD as necessary for the benefit of my treatment. I understand that my medical and personal information will be kept private and confidential and will only be disclosed to 3rd parties with permission. INITIALS:I have read the above agreement and understand that I am responsible for all charges relating to my appointment with Kamloops Integrated Wellness.Signature (parent or guardian if <18 years old): Date:  |

MEDICAL HISTORY

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| INJURY INFORMATION |
| Please indicate on the diagram your current area(s) of injury/concernPlease tell us about your current injury (e.g. how and when did it start, aggravating and relieving factors, etc.)  |
| Have you seen any other practitioners for this injury? Yes NoIf yes, please provide name(s) and occupation: |
| MEDICAL HISTORY |
| Please list all prescription medications you are currently taking and their purpose | Please list all vitamins/supplements you are currently taking | Please list ALL previous surgeries and dates performed | Please list all major traumas and illnesses experienced (e.g. car accidents, broken bones, cancer) |
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| Please circle any condition/injury that applies to you. Your practitioner will review your history in detail during your visit |
|  Pregnant (week#)Miscarriage (#)Vaginal delivery (#)C-Section (#)MenopauseIncontinenceMigraines/Recurring headaches  | FibromyalgiaDepressionAnxietyInsomniaSleep apneaVaricose veinsLocation:Celiac/IBSCrohn’s/ColitisStomach ulcer | PacemakerHeart diseaseHigh CholesterolStrokeHeart AttackAneurysmHigh/Low Pressure (circle)EpilepsyHead injury | Cancer HIVHepatitisSmoker (# of years: )Trouble with visionTrouble with hearingDiabetes (type: )Onset:ConstipationHeart burn | OsteoarthritisRheumatoid ArthritisScoliosisOsteoporosisConcussionsDizziness/FaintingAllergiesAsthmaCOPD/emphysema  |
| Please list any other health conditions not mentioned above: |
| Please list your regular activities and/or hobbies: |
| Name (please print): |