Office Policies

Welcome to WAKE Wellness,

It is our optimal goal to provide you and your family with the highest quality of care, while maintaining a friendly and relaxing environment. To keep our standard of care to a level which best serves your needs, we ask that you please observe the following guidelines:

If an appointment must be changed, 24 hours' notice is required so that the practitioner may service others during that allotted time. Please let the receptionist know and changes will be made accordingly. If failure to provide notice occurs, you will be subject to a short-notice cancellation/missed appointment fee. For chiropractic care, it is recommended that any missed appointments be made up later in the same day or within 7 days to prevent loss of spinal correction.

Payment is due at the time of the office visit unless we are billing your extended health insurance, motor vehicle insurance or WSIB directly. Please let us know if you wish to pay by cash, debit, or credit (visa or MasterCard accepted). Receipts will be issued at the time of the visit or annually.

You will achieve the best results when you follow the practitioner's recommended appointment schedule and home care advice. Remember: healing takes time. If you do not feel satisfied with your body's responses, please discuss this with your practitioner. We want you to get the most from your care. Please speak with us if you have any concerns – your comments will help us to help others.

I _____authorize my healthcare provider to collect, use and disclose personal information concerning any insurance claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) relating to my clinic visits and charges.

I recognize that when providing an email address on clinic intake forms, I am consenting to receive appointment reminder emails and the occasional newsletter or promotional email from WAKE Wellness.

I agree and consent to the above written terms.

Signature:_____ Date:_____

www.wakewellness.ca
(705) 245-9253
Info@wakewellness.ca

New Patient Intake Form

Name:_____ **Date:**_____

Home Phone #:_____ **Work Phone #:**_____

Home Address:_____ **City:**_____ **Postal Code:**_____

Medical Doctor:_____ **Email Address:**_____

Gender: Male_____ **Female**_____ **Age:**_____ **Birth Date:**_____

Marital Status: (circle one) M S W D **Spouse's Name:**_____

Children's Names and Ages:_____

Occupation:_____ **Work Activity:** ____Sitting ____Standing ____Manual labour

Do you have Extended Health Care? N or Y: ____Chiropractic ____Orthotics ___Massage ___Acupuncture

How did you hear about our clinic? ____Referral ____Doctor ____Website ____Advertising ____Other

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Present Complaint

Are you here because of: work related injury Yes____ No____ Auto accident Yes____ No____

What is your presenting complaint? Where do you feel the problem?

_____

_____

When did this start?_____ **How did it start?**_____

Have you had this similar condition before? N or Y:_____

How bad is your pain/ache? (circle one) 0 1 2 3 4 5 6 7 8 9 10 (0 - no pain & 10 - most pain)

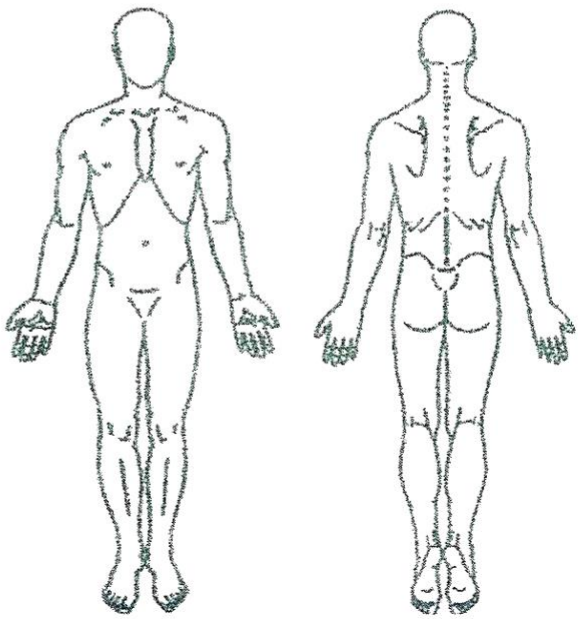
How frequent is your problem? ____constant ____frequent ____occasional ____comes & goes

What activities aggravate your condition?_____

Do you feel your condition is getting: ____worse ____better ____no change

On the body diagrams to the right, please indicate your areas of symptoms by drawing in the appropriate symbols.

P – pain
N – numbness
W – weakness
S – shooting
A - aching



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Have you ever been to a chiropractor before? ____No ____Yes (name):_____

List previous treatments you have received for this present condition:_____

Do you smoke? ____No ____Yes **Do you exercise?** ____No ____Yes (activities):_____

Rate your sleep, hours per night: < 4 4 – 6 6 – 8 8 – 10 12+

Rate your diet: Poor Fair Medium Good Excellent

Please list all medications you are currently taking:_____

Please list any surgeries and operations:_____

Please list any family medical conditions: (Ie. Diabetes, Stroke, High Blood Pressure, Cancer, Heart Disease)

_____

Please view carefully, and indicate if you have experienced any of the following symptoms with an X.

General	**Eyes, Ears, Nose, Throat**	**Genito-Urinary**
_____ Chills	_____ Deafness	_____ Blood in urine
_____ Convulsions	_____ Ear aches	_____ Frequent urination
_____ Dizziness	_____ Ear ringing	_____ Loss of control
_____ Fainting	_____ Sinus infection	_____ Kidney infection
_____ Headaches	_____ Enlarged Glands	_____ Bed wetting
_____ Loss of Sleep	_____ Enlarged Thyroid	
_____ Nervousness	_____ Sore throat	**Pain or Numbness in**
_____ Depression	_____ Tonsillitis	_____ Arms
_____ Neuralgia	_____ Eye pain	_____ Hands
_____ Numbness	_____ Hay fever	_____ Hips
_____ Sweats	_____ Hoarseness	_____ Legs
_____ Loss of weight	_____ Nosebleeds	_____ Knees
_____ Tremors		_____ Ankles
_____ Allergy	**Cardiovascular**	_____Painful tail bone
_____ Fibromyalgia	_____ Rapid heart beat	_____ Sciatica
	_____ Slow heart beat	_____ Shoulders
Muscle and Joint	_____ Swelling of ankles	
_____ Bursitis	_____ Hardening of arteries	**Gastro intestinal**
_____ Foot Trouble	_____ Pain over heart	_____ Excessive hunger
_____ Hernia	_____ Heart attack	_____ burping or gas
_____ Low back pain	_____ Stroke	_____ Colitis
_____ Neck pain	_____ High Blood Pressure	_____ Constipation
_____ Arthritis	_____ Low Blood Pressure	_____ Diarrhea
_____ Osteoporosis	_____ Poor circulation	_____ Stomach pain
_____ Swollen Joints		_____ Nausea
	Skin	_____Vomiting
Respiratory	_____ Bruise easily	_____ Poor appetite
_____ Chest pain	_____ Hives or allergy	
_____ Chronic cough	_____ Itching	
_____ Wheezing	_____ Varicose Veins	
_____ Asthma		

Dr. Initial:_____ Patient initial:_____