SHIN Integrative Health Group Ltd.
Patient Medical History and Intake Form

The information requested below will assist us in providing a safe treatment. Feel free to ask questions. Please, note that all information will be kept confidential unless consent from the patient is provided or is required by law. We do not direct bill ICBC or WCB claims.

Legal First Name: Date of Birth:
Legal Last Name:
Other Preferred Name: Occupation:
Address:
Primary Number: Family Doctor:
E-mail: (Phone):
ICBC or WCB claim? ☐No ☐Yes claim#:
How did you hear about our clinic?

Emergency Contact Information:
Full Name:
Phone Number: Relationship:

Please, indicate all condition(s) that you are experiencing or have experienced/tested positive.

Respiratory:	Cardiovascular:	Soft tissue and joints:
○ Chronic cough ○ Difficulty breathing ○ Chest Pain ○ Sore throat ○ Bronchitis ○ Runny or stuffy nose ○ Loss of sense of smell ○ Asthma ○ COPD ○ Influenza, Flu ○ COVID-19	○ High blood pressure ○ Low blood pressure ○ Stroke/aneurysm ○ Heart Attack ○ Varicose veins ○ Pace maker ○ Bruise easily ○ Heart conditions	○ Sprains/Strains ○ Joint Dislocations ○ Joint replacement ○ Implants ○ Ulcers ○ Skin rash or fungus ○ Muscle Aches
Head and Neck: ○ Headaches/Migraines ○ Vision issues ○ Hearing issues ○ Fever ○ Dizziness, Drowsy	Other : ○ Fractures ○ Pins/rods/plates ○ Shunts ○ Osteoporosis ○ Diabetes ○ Loss of sensation ○ Arthritis ○ Epilepsy ○ Fatigue ○ Diarrhea/Constipation ○ Cancer ○ Depression/Anxiety ○ HIV/Hepatitis/Herpes ○ TB	Is there family history of any conditions listed or other? ☐ Yes ☐No Which: _____ Contact lenses: ☐Yes ☐No Other conditions/ Details: _____ _____ _____ _____ _____ _____ _____ _____
Pregnant □ Yes □ No Due: _____ Complications: _____		

❖Please list any current medications, their purpose of taking and if known side effects:

_____

_____

❖Please list any known allergies/sensitivities (Oils, lotions, medications, latex, seasonal, others):

_____

❖Have you been hospitalized, had surgery, accident, illness: ☐ Yes ☐ No When:
Describe: _____

❖Are you receiving treatment from another health care professional? ☐ Yes ☐ No For what:

_____

❖What other therapies have you had? When:_____
☐ Massage Therapy ☐ Physiotherapy ☐ Acupuncture ☐ Chiropractor ☐ Other:
Describe: _____

❖List any activities, sports or hobbies: _____

❖Do you smoke? □ Yes □ No □ Ocassional ❖Did you have alcohol in the past 12hrs? □Yes □No

❖<u>CURRENT CONDITION</u>:
Please, RATE how you PRESENTLY feel: 1=POOR 2=FAIR 3=GOOD 4=EXCELLENT
Stress Level: Quality of sleep: How many hours do you sleep:
Exercise Habit: Energy Level: How many times a week do you exercise:

Describe your current condition/symptoms:

_____
_____
_____

How long have you had symptoms/condition?

_____

How did it start?

_____
_____

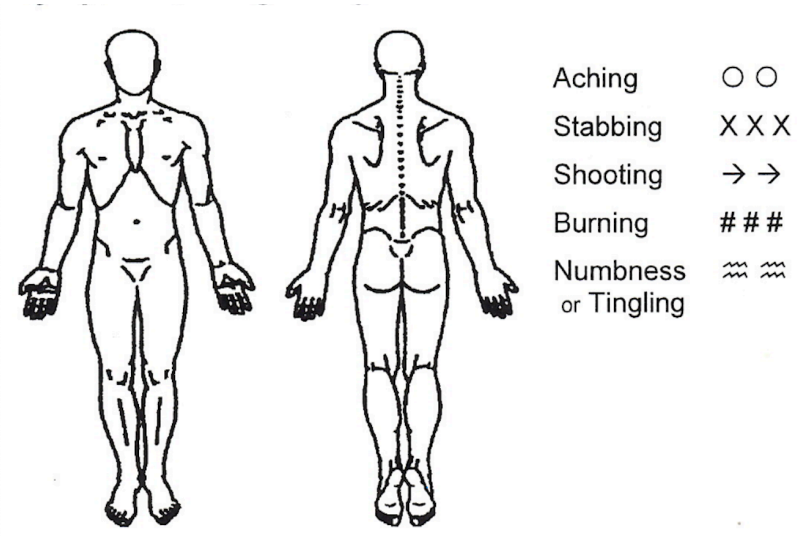
What aggravates it?

_____

What relieves it?

_____

O Indicate in the diagram all that apply:



<u>Please note</u>: Your appointment time has been reserved for you. In courtesy of your practitioner and patients, we ask you to provide us with 24hrs notice of cancellation to avoid charges. It is NOT legal to bill your Extended Health Benefits for No-Show or late cancellations. It is the patient's responsibility to assume those charges. I authorize the clinic and their RMTs to collect my personal and medical information to contact me in regards to appointments and/or clinic updates. I authorize the clinic and t RMTs to communicate with my MD as deemed necessary for my beneficial treatment. I understand that my personal information confidential and will only be disclosed with my permission.

➔ <u>Signature</u>: ➔<u>Date:</u>