Collective Foot and Wellness Clinic
1423 Upper Ottawa Street, Units 4&5
Hamilton, ON L8W 3J6
Phone: 905-527-4817
Fax: 905-667-4810
info@happytoes.ca

INITIAL ASSESSMENT FORM

First name: ________________________________ **Last name:** ____

Preferred name: ______________________ Preferred pronouns: ☐ She/Her ☐ He/Him ☐ They/Them Other: ________

Date of birth: ____________________________Occupation: ____

Address: ____ City: ______________________________

Postal code: _______________________ Phone: (H) _______________________ (C) ___________________________

How would you like appointments confirmed?

☐ Email address: ____ ☐ SMS/Text ☐ Phone

Emergency contact: First name: __________________________ Last name ____________________________________

Relationship: ___________________________________ Phone: ____

How did you hear about our clinic?
☐ Advertisement ☐ Internet ☐ Doctor ☐ Other (please specify) _________________☐ Friend / family _______________

If patient is a dependant, please provide the following:

Parent/Guardian Name: ____ Relationship: _________________________

Address (if different from the patient): ____

____

Are you here as a result of a workplace injury (WSIB)? ☐ Yes ☐ No If yes, please provide the following information:

Claim #: _______________________________________ The date of the accident: M: ______ D: ______ Y: ___________

What is the area of injury?: ____

Our services <u>are not covered</u> by OHIP. If you have an Extended Health Plan, please check into your plan to determine any coverage you may have. If you have an Extended Health Plan, please check into your plan to determine any coverage you may have. We do offer direct billing for our Physiotherapy, Chiropractic, Osteopath and Registered Massage Therapy services.

If you would like us to direct bill for your appointment, please fill out the below information:

Insurance Company Name: ____

Plan/ID/Policy # ____________________________________ Member/Contract # _______________________________

Primary plan holder name: _______________________________ Relationship to primary plan holder: _______________

Please indicate conditions you are experiencing or have experienced:

Cardiovascular:
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chronic Congestive Heart Failure
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Palpations
- ☐ Heart Murmur
- ☐ Stroke / CVA
- ☐ Aneurism
- ☐ Angina
- ☐ Blood Clots
- ☐ Raynaud's Disease
- ☐ Phlebitis / Varicose Veins
- ☐ Poor Circulation
- ☐ Pacemaker or Similar Device

Respiratory:
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sinusitis
- ☐ Sinus Congestion

Do you smoke? ☐ Yes ☐ No

Blood:
- ☐ Anemia
- ☐ Hemophilia
- ☐ Leukemia
- ☐ Hepatitis A B C

Lifestyle:

Regular Exercise
☐ Yes ☐ Mostly ☐ No

Drink Plenty of Water
☐ Yes ☐ Mostly ☐ No

8 Hours of Sleep Nightly
☐ Yes ☐ Mostly ☐ No

Good Eating Habits
☐ Yes ☐ Mostly ☐ No

Gastrointestinal:
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas / Bloating
- ☐ Nausea / Vomiting
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's / Colitis
- ☐ Hernia
- ☐ Ulcers
- ☐ Gall Bladder Problems
- ☐ Liver Problems
- ☐ Kidney Infections
- ☐ Bladder Infections
- ☐ Urination Problems
- ☐ Poor Appetite
- ☐ Excessive Thirst

Skin:
- ☐ Allergies:
- ☐ Hypersensitivity
- ☐ Bruises Easily
- ☐ Rashes
- ☐ Eczema
- ☐ Psoriasis
- ☐ Athletes Foot
- ☐ Herpes
- ☐ Warts
- ☐ Skin Conditions:

Women:
- ☐ Pregnant, Due:
- ☐ Infertility
- ☐ Menstrual Concerns / Pain
- ☐ Menopausal Concerns
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Hysterectomy
- ☐ Vaginal Pain / Infection

General Health:
☐ Good ☐ Fair ☐ Poor

Other (please list):

Head / Neck:
- ☐ Headaches
- ☐ Migraines
- ☐ Whiplash
- ☐ Jaw Pain
- ☐ Ear Pain
- ☐ Hearing Problems
- ☐ Hearing Loss
- ☐ Vision Problems
- ☐ Vision Loss

Muscle / Joint:
- ☐ Muscle Strain
- ☐ Ligament Sprain
- ☐ Spasms / Cramps
- ☐ Tendinitis
- ☐ Bursitis
- ☐ Fibromyalgia
- ☐ Ankylosing Spondylitis
- ☐ Arthritis OA RA
- ☐ Osteoporosis
- ☐ Herniated Disc
- ☐ Degenerative Discs
- ☐ Joint or Bone Disease
- ☐ Scoliosis
- ☐ Dislocation
- ☐ Fracture

Other Conditions:
- ☐ Diabetes, onset:
- ☐ HIV / AIDS
- ☐ Cancer
  Type?
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Thyroid Disorders
- ☐ Lupus
- ☐ Loss of Sensation
  Where?
- ☐ Insomnia / Fatigue
- ☐ Fainting / Dizziness
- ☐ Anxiety / Nervousness
- ☐ Depression
- ☐ Alcohol / Drug Addiction

Is there a family history of any of the conditions listed above?

Do you have any internal pins, wires, artificial joints or special equipment? ☐ Yes ☐ No

If yes, where?

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Describe your reason for seeking our services today:

____
____

Have you sought treatment from any other health care professionals for this issue? □ Yes □ No
If yes, please specify: ____

Current Allergies: □ Yes □ No (if yes, please specify): ___________________________________

Patient physicians & medical specialists:
Family Physician Name: ________________________
Phone #:________________________________
Other doctor: ___________________________
Phone #: ______________________________

Please list your current medications:
____
____
____
____

Previous Injuries/Surgeries:

Name of Procedure: _________________________ Date of procedure: _________________________
Name of Procedure: _________________________ Date of procedure: _________________________
Name of Procedure: _________________________ Date of procedure: _________________________

Is there anything else we should know about your health?

____
____

Please ensure you read the following information in its entirety.

I have stated all my previous and current medical conditions. I will update my provider regarding any updates in my condition as soon as possible.

To provide treatment, this clinic must collect personal health information. I understand that all information that I provide will be kept confidential unless allowed or required by law. I understand that I will be asked for written authorization before this information can be released.

I have reviewed the above information:

Name: ____

Signature: ____Date: _____________________