MAPLE SHORES HEALTH CENTRE
593 Mill Street, Box 777, Port Elgin, ON, 519-832-4500, Fax 1-519-488-3636
Anthony Kaake, R.M.T & D.O.M.P

Dear New Patient,

Thank you for your interest in Osteopathy and Advanced Massage Therapy. You have just taken an important step towards optimizing your body and overall health. It is essential during the treatment process that you remember to be patient with your body, as is it may take several appointments to notice significant improvements within the body.

Please fill out these new patient forms and bring them to your first visit. These forms include the systems review, and a consent form. Please note that the intake form asks for your email address. With your consent, this will be used only for the purposes of electronic appointment reminders as well as periodic patient emails regarding relevant health and office information. The information you share on the intake and during all appointments will be kept confidential and will not be shared with anyone else, unless your written consent is given to do so.

The first visit will be approximately 45 minutes in length where we will discuss what injury or ailment you are seeking treatment for. The appointment will also involve taking a detailed health history including reviewing past injuries that can often play a large role in present issues you may be experiencing. Please wear loose fitting comfortable clothing to the appointment and be prepared that you may receive hands on treatment within your first visit. Along with hands on treatment plans our Osteopath team also uses modalities such as: Laser, Deep Oscillation, FSM and Vibrocussor to enhance your healing process. You will leave your first appointment with a clear treatment plan that includes detailed follow up instructions. Subsequent follow up visits are typically weekly or biweekly after the initial visit, lasting approximately 4-6 weeks. The optimal treatment plan will differ with every patient and condition being treated; your specific treatment plan will be discussed with you at your visit.

Please note that payment is due at the end of your visit. For your convenience we accept Visa, Mastercard, Debit, cash and cheque. If you are unable to make a scheduled appointment, please give at least 24 hrs notice, so that time can be made available to another patient. If less than 24hrs notice is given, you will be charged the full appointment fee for the scheduled visit.

Maple Shores Health Centre is located at the northwest corner of Goderich Street (Hwy 21) and Mill Street. Free street parking is available on all of the downtown streets. There is also a free public parking lot off of Elgin Street (one street north of Mill Street), behind the Port Elgin Library, that is a short walk to the clinic.

If at any time you have questions or concerns about your treatment, please feel free to voice them during your visits, or contact the office at (519) 832-4500. I look forward to working together with you to help you enjoy long lasting health improvements.

Yours in health,

Tony Kaake, RMT, DOMP
Reg. Massage Therapist and Osteopath

ADULT INTAKE FORM

Last Name:_____ First Name:_____

Address:_____City:_____ Postal Code: _____

Phone (home):_____Phone (work):_____Phone (cell):_____

E-mail_____

Date of Birth (DD/MM/YYYY)_____Age:_____

Occupation:_____ Marital Status: _____ Number in household:_____

Emergency Contact Name:_____ Phone:_____

How did you hear about the clinic?: _____

Do you consent for your e-mail to be used for the purposes of appointment reminders and occasional emails regarding relevant office and/or health information? You may contact the office at any time to withdraw your consent. ***YES*** ***NO*** *(please circle)*

THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON, EXCEPT FOLLOWING YOUR WRITTEN AUTHORIZATION. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE.

Other health care providers:

Name:_____ Designation:_____ Phone:_____

Name:_____ Designation:_____ Phone:_____

Name:_____ Designation:_____ Phone:_____

Please list the health concerns that bring you to Maple Shores Health Centre:

_____

_____

_____

What specialists have you seen? (Indicate the year of consultation, if possible)

_____

_____

_____

If you are female, are you currently pregnant? YES NO

MEDICATIONS:

Please list all **CURRENT prescribed medications you are taking**.

Medication	Dose	How long taken	Reason for Use

How many times have you been treated with antibiotics in the past 5 years? _____

Please list any **over the counter medications you are presently taking** (e.g. Aspirin, Tums).

Medication	Dose	How long/often taken	Reason for Use

Please list any **vitamins/minerals, herbs or homeopathic remedies that you take on a regular basis**:

Supplement	Dose	How long taken	Reason for Use

Please list all sensitivities/allergies/reactions to the following:
Drugs:_____
Environment:_____
Food:_____

FAMILY MEDICAL HISTORY:

Relation	Age	Health problems	Cause, if deceased
Father			
Mother			
Grandparents			
Sibling(s)			
Children			

MEDICAL HISTORY:

Date of last physical exam: _____Reason for the exam? _____

Do you have regular SCREENING TESTS done by another doctor? (Pap, blood tests, etc.) YES NO
Please list: _____

PERSONAL HEALTH HABITS:

Height:_____ Current weight: _____ Weight 1 year ago: _____ Max weight:_____ Year:_____

Smoker? YES NO Amount/day?_____# Years smoked?_____ Year stopped? _____

Are you exposed to second hand smoke? YES NO Where? _____

Alcohol use? YES NO Type: _____ Frequency: _____

Recreational drug use? YES NO Type: _____ Frequency: _____

Caffeine use (coffee, tea, pop)? YES NO Type: _____ Frequency: _____

Amount of fluids/day: _____ Amount of water/day: _____

Please list any foods that you crave: _____

How many meals do you eat in a day? 1 2 3 4 More than 4

Please describe a typical day's diet:
Breakfast_____
Lunch_____
Dinner_____
Snacks, including drinks _____

Are you frequently exposed to animals? YES NO Type? _____

Do you exercise regularly? YES NO Type: _____ Frequency: _____

How many hours of sleep do you get per night? _____ Do you wake rested? YES NO

Do you have problems falling or staying asleep? (If yes, please circle which one)

How many hours do you work each day? _____ Is it shift work? YES NO

ENVIRONMENTAL EXPOSURE

Did you grow up near an industrial/polluted area, or in a home with lead paint? YES NO

Have you ever had a job where you were exposed to solvents, heavy metals, fumes, or other toxic materials?
YES NO
Have you ever had health problems when you have renovated or refurbished your home? YES NO

Do you react when exposed to perfumes, gasoline or other scents? YES NO

Do you use pesticides, herbicides and other chemicals around your house? YES NO

Please rate your satisfaction with each of the following areas of your life: (4 = highest satisfaction)

HEALTH	0	1	2	3	4
DIET	0	1	2	3	4
LIFESTYLE	0	1	2	3	4
WORK	0	1	2	3	4
FAMILY	0	1	2	3	4
RELATIONSHIPS	0	1	2	3	4

Rate your overall stress level: Low Average High Very high Unbearable

What areas of your life contribute the most to your stress (please circle)?
Work Health Family Money Marriage Other: _____

Do you have an active spiritual practice? YES NO Do you have a good support network? YES NO

What do you do for fun/stress relief? _____

When was your last vacation? _____ How often do you take a vacation? _____

CHRONOLOGICAL HEALTH HISTORY:

This portion of the health history form helps to establish patterns in your life that may be relevant to your present health concerns. Please indicate any surgeries, hospitalizations, injuries, accidents, broken bones, falls, illnesses, and/or any emotional stresses or traumas (deaths, loss of job, divorce, etc.)with appropriate explanations, including dates and your age at the time.

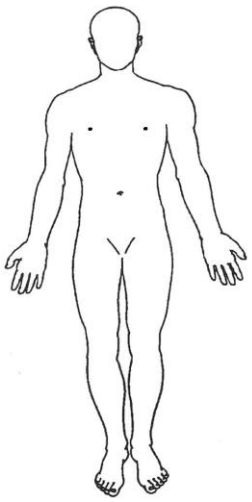
Age 0-4 _____
Age 5-9 _____
Age 10-15_____
Age 16-20_____
Age 21-25_____
Age 26-30_____
Age 31-35_____
Age 36-40_____
Age 41-45_____
Age 46-50_____
Age 51-55_____
Age 56-60_____
Age 61-65_____
Age 66-70_____
Age 71 + _____

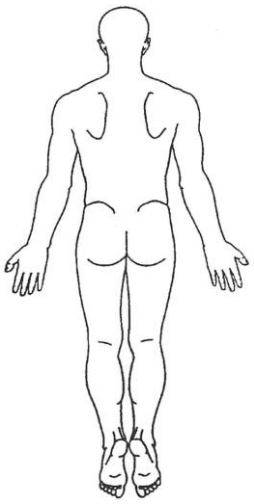
What are your short-term health goals? _____
_____

What are your long-term health goals? _____
_____
_____
_____

How committed are you to making the necessary lifestyle changes? VERY SOMEWHAT NOT VERY

Please list any other relevant health/ personal information that you feel is missing:
_____
_____
_____
_____





[ ] Should I wish to see other practitioner(s) within the scope of the Maple Shores Health Centre, I agree to the sharing and dissemination of pertinent medical information between practitioner(s) within your office.

OR

[ ] I do not wish to have my medical information shared with any other practitioner(s) at the Maple Shores Health Centre.

Cancellation Policy – 24 hours notice is required to change or cancel your appointment or the full fee will be charged.

Missed Appointments – A missed appointment will be charged the full fee. Thank You

Signature:_____ Date: _____

Thank you for choosing the Maple Shores Health Centre for your health care needs.
Helping you live better…now and into the future

SYSTEMS REVIEW

Below is a list of symptoms which may or may not seem relevant to your current health concerns. Please answer as accurately and completely as possible as a detailed health history is necessary to develop a personalized health plan. The relevant issues brought up by this questionnaire will be discussed during your visit.

Please check (√) **"C"** if you currently have the symptom or **"P"** if you have had it in the past 6 months.

Skin	**C**	**P**
Rashes		
Hives		
Acne		
Boils		
Eczema		
Psoriasis		
Dry skin		
Itching		
Lumps		
Night sweats		
Other		

Head	**C**	**P**
Tension headaches		
Migraine headaches		
Head Injury		
Dizziness		
Other		

Eye	**C**	**P**
Impaired vision		
Use of contact lenses/ glasses		
Eye pain		
Tearing		
Dryness		
Double vision		
Glaucoma		
Cataracts		
Blurring		
Light Sensitivity		
Itching		
Redness		
Discharge		
Blind spot		
Other		

Ears	**C**	**P**
Impaired hearing		
Earache		
Dizziness		
Discharge		
Infections		
Excessive wax		
Other		

Nose & Sinuses	**C**	**P**
Frequent colds		
Nose bleeds		
Stuffiness		
Hay fever		
Infections		
Other		

Mouth & Throat	**C**	**P**
Hoarseness		
Gum problems		
Difficulty swallowing		
Dental problems		
Sores		
Dryness		
Sore throat		
Loss of taste		
How often do you brush your teeth?		
Do you floss?	Y	N
How often do you see a dentist?		

Neck	**C**	**P**
Lumps		
Swollen glands		
Goiter		
Pain or stiffness		
Other		

Respiratory	**C**	**P**
Cough		
Sputum		
Spitting up blood		
Wheezing		
Asthma		
Bronchitis		
Pneumonia		
Pleurisy		
Emphysema		
Pain on breathing		
Shortness of breath		
Positive tuberculin test	Y	N
Last TB test		
Last chest x-ray		
Other		

Cardiovascular	**C**	**P**
Angina		
Murmurs		
Chest pain		
Swelling in ankles		
Palpitations, fluttering		
Last ECG		
Other		

Breasts	**C**	**P**
Do you perform self breast exams?		
Lumps		
Pain (or tenderness)		
Nipple discharge		
Last mammogram		
Other		

Gastrointestinal	**C**	**P**
Vomiting		
Heartburn		
Change in appetite		
Nausea		
Frequency of Bowel Movements per day	1 2	3+
Vomiting blood		
Belching		
Passing gas		
Abdominal pain		
Indigestion		
Diarrhea		
Constipation		
Blood in stools		
Hemorrhoids		
Black, tarry stool		
Jaundice		
Liver disease		
Gallbladder disease		
Food allergy		
Hiatus hernia		
Other		

Blood/Lymphatic	**C**	**P**
Anemia		
Easy bleeding/ bruising		
Past transfusions		
Lymph node swelling		

Please check (√) **"C"** if you currently have the symptom or **"P"** if you have had it in the past 6 months.

Urinary	C	P
Pain on urination		
Increased frequency		
Frequency at night		
Inability to hold urine		
Frequent infections		
Kidney stones		
Blood in urine		
Reduced urine flow		
Other		

Musculoskeletal	C	P
Broken bones		
Muscle spasms/cramps		
Weakness		
Joint swelling		
Backache		
Other		

Peripheral vascular	C	P
Deep leg pain		
Cold hands/ feet		
Varicose veins		
Leg cramps		
Extremity numbness		
Extremity swelling		
Extremity ulcers		
Other		

Neurologic	C	P
Fainting		
Seizure/ Convulsions		
Paralysis		
Muscle weakness		
Numbness or tingling		
Loss of memory		
Involuntary movements		
Loss of balance		
Speech problems		
Other		

Endocrine	C	P
Heat/ cold intolerance		
Thyroid trouble		
Excessive thirst		
Excessive hunger		
Excessive sweating		
Diabetes		
Low blood sugar		
Other		

Emotional	C	P
Depression		
Extreme anger		
Mood swings		
Anxiety		
Nervousness		
Tension		
Phobias		
Insomnia		
Sexual difficulties		
Drug abuse		
Psychiatric care		
Psychological counseling		
Other		

Male Reproductive	C	P
Hernia		
Testicular mass		
Testicular pain		
Impotence		
Premature ejaculation		
Venereal disease		
Discharge of sores		
Sexually active		
Circle sexual preference: Heterosexual/ Homosexual/ Bisexual		
Last prostate exam:		
Last PSA level:		
Other		

Female Reproductive	C	P
Age of first menses:		
Last menstrual period:		
Number of days of menses:		
Length of cycle:		
Bleeding between periods		
Irregular cycles		
PMS		
Heavy flow		
Painful menses		
Menopause		
Age of onset:		
Hormone therapy		
Last gynecological exam:		
Number of pregnancies:		
Number of live births:		
Number of miscarriages:		
Number of abortions:		
Difficulty conceiving		
Vaginal discharge		
Vaginal itching		
Sexually active		
Pain during intercourse		
Circle sexual preference: Heterosexual/ Homosexual/ Bisexual		
Other		