Dr. Christopher Notley

www.DrNotley.com

Please fill out this intake form. It should take between 5 to 10 minutes to complete. Then print the document, double sided, and fill in the chart and sign the document. Please bring the document to your first visit. Answer what you can. Further questions will be asked during your first visit.

PATIENT INTAKE:

Name _____Date of Birth (MM/DD/YYYY) _____

Address _____
Unit/Street number City Province Postal Code

Contact phone numbers: _____/_____ E-mail _____

Occupation _____ Employer _____

MHSC # (six digit) _____ PHIN # (9 digit) _____

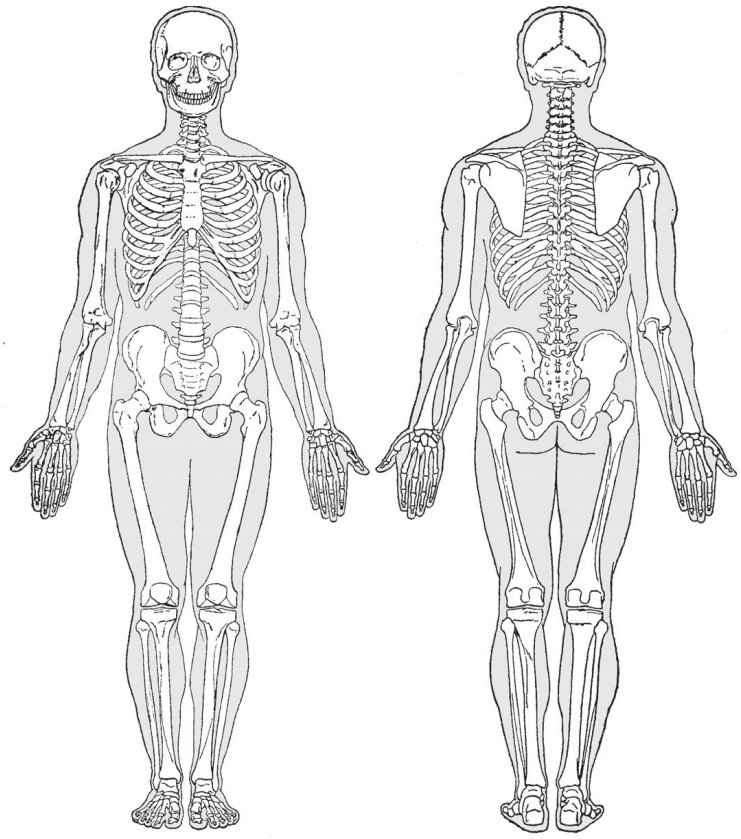
Insurance plan & number: _____

Recent motor vehicle accident (MPI) Yes / No MPI Claim Number _____ Date of Accident: _____

Work related injury / accident (WCB) Yes / No WCB Claim Number _____ Date of Accident: _____

How did you learn about our office?

Reason for consulting this office:



1. What is your reason for this appointment?

2. When did it start?

3. Describe your discomfort.

4. **Indicate the areas on the diagram where you feel any of the following symptoms:**
   - Numbness
   - Pins & Needles
   - Burning
   - Aching
   - Stabbing
   - Soreness
   - Stiffness
   - Pain

5. One a scale of 0 to 10 how would you rate your discomfort? Zero is no discomfort and 10 is the worst discomfort imaginable.

6. Is the discomfort **CONTINUOUS** or **PERIODIC? (circle)**

7. Is it getting better, worse, or staying the same (circle)

8. Is there a time of day that there is more discomfort?

9. What positions, activities or movements make it worse?

10. What positions, activities or movements make it better?

Past medical history

1. Has this discomfort happened before?
2. Were you treated for it? By whom?
3. Did the discomfort resolve?
4. Please list any past muscle and joint injuries, past motor vehicle accidents, surgeries or hospitalizations

PERSONAL HEALTH HISTORY:

1. On average, how would you describe your health? Poor Neutral Good Excellent
2. Have you had the following? Circle Yes or No

A history of Cancer?	Yes	No
Unexplained weight loss?	Yes	No
Night Pain, unrelated to movement?	Yes	No
Severe fever or chills?	Yes	No
A recent bacterial infection?	Yes	No
Prolonged steroid use?	Yes	No
Osteoporosis?	Yes	No
Pain in your arm/leg that is greater than your neck/back pain?	Yes	No

MEDICATIONS YOU NOW TAKE: (please circle)

Anti-inflammatory	Tranquilizers	Thyroid
Pain Killers	Insulin	Anti-depressants
Muscle Relaxants	Birth Control Pills	Anti-anxiety
Blood Pressure	Cholesterol	

Other medication:_____

Date of Last Medical Examination: _____

I acknowledge to the best of my knowledge that this information is accurate and true.

_____ _____

SIGNATURE **DATE**