ARU CHIROPRACTIC
519-623-5777

Patient Intake Form for James Aru M.Sc., D.C.

Please complete as fully as you can:

Full Name:			
Address:		City:	
Postal Code:			
Email address:		**May we contact you via text/Email? Y / N**	
Telephone:	Cell:	Home:	
Date of Birth: YY/MM/DD		Age:	

Marital Status:			
Name Of Spouse:		Children:	
Place of Work:		Position:	
Extended Health Insurance: Y/N	Name of Company:		Amount of Coverage:

What Is The Reason For Your Visit?	
When Did You First Notice The Problem:	
Was It A Result Of Accident?	Please Explain
Are There Secondary Complaints?	
Other Doctors Seen For This Condition:	
Primary Care Physician:	Date Of Last Physical Examination:
Any Unusual Findings:	
Have You Been Treated For Any Other Problem By A Physician In The Last Year?	Please Describe:
What Prescriptions Are You Taking?	

How did you hear about us?	
Have You Been To Another Chiropractor Before?	If Yes, Doctor's Name: When_____ Results_____
Are There Recent X-Rays Available?	

General information: Have you ever suffered from: (Please Circle)

Dizziness	Backache	Heart Trouble	Headaches	Arthritis	Digestive Disorders	Asthma	Rheumatic Fever
Sinus	Neuritis	Cancer	Diabetes	Tuberculosis	Anemia	Numbness	Nervousness

**Please add any additional Details to back of page.

Signature: _____ Date:_____

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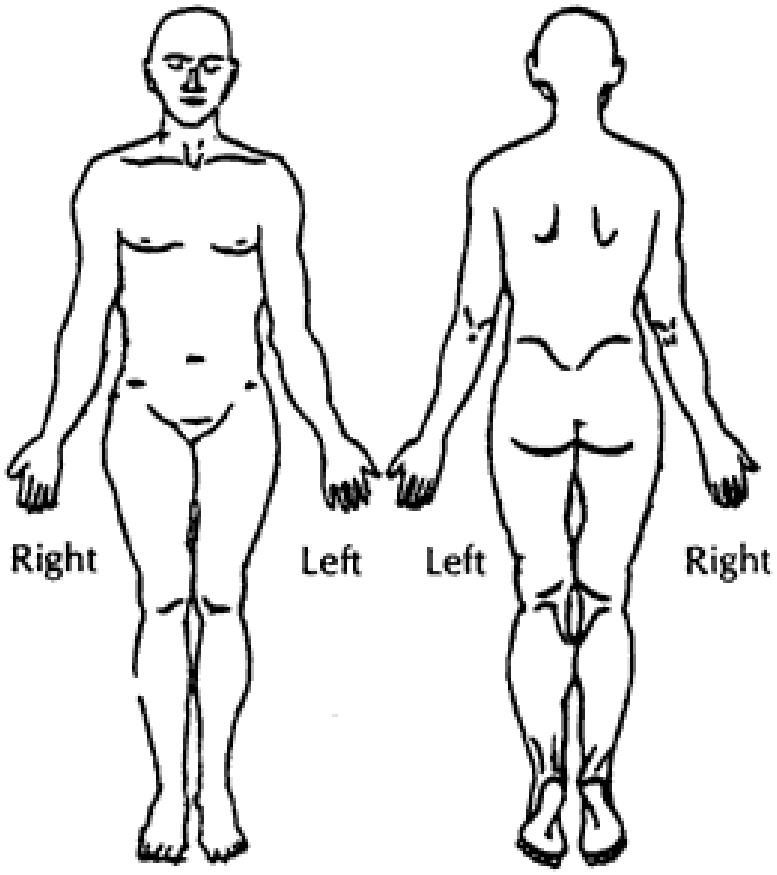
PAIN CHART

Name: _____ Date: _____

Where is your pain?

Please mark on the drawings below the areas where you feel your pain.



RATE YOUR PAIN 0 – 10 Scale

Pain at best / 10

Pain on average / 10

Pain at worst / 10

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PIPEDA and PHIPA Document Access

As of January 1, 2004 the Federal Government put in place an act that protects you the client regarding your personal information called Personal Information and Protection of Electronic Documents Act (PIPEDA).

It sets out rules as to how the private sector may collect, use or disclose personal information.

As of November 1 2004 Personal Health Information Act (PHIPA) was put in place. This act applies to health workers in clinical practice. It is set to protect your personal health information. It relies on implied consent for use of information for treatment (within the circle of care).

Both acts are to ensure that I do not use your personal or health care information for any other purpose than it was intended. File information and treatment within my clinic. As well as assuring you that it is safeguarded and you have right to access your file at any given time.

The only way information can be released is by your request or obtaining your consent, supported with your signature and your full understanding to what the information is being released for.

Once again, access to your file is your right and you may request to set up an appointment to view it at any time.Once you have read this and understand or have had a chance to ask questions or if requested given access to documents PIPEDA and PHIPA you will then sign this form.

Signature:	
Print Name:	Date:

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Electronic Transmission Consent Form (Insurance)

Instructions: This Form must be filled out when claims are submitted electronically by the provider on a patient's behalf. Keep in file for verification purposes.

Provider:	Dr James Aru #5322: Aru Chiropractic
	350 Conestoga Bld Unit B2A
	Cambridge On N1R 7l7
Patient:	**Name as printed on Insurance:**
Date of Birth:	
Insurance Company:	
Insured Member:	
Plan Number:	
Certificate /Member #:	
Amount of Coverage:	

*Taking a photocopy of insurance card or sending a screenshot to office@aruchiropractic.com would be helpful.

Consent to Transmit Information Electronically:

I hereby authorise the electronic transmission of all information included in my health insurance claims to my plan administrator or the administrator's designated representative(s). I also confirm that I am authorized by my spouse and /or dependents (if any) to disclose personal information about their claim and assign benefit payments to relevant organizations. In the event of suspected fraud and or plan abuse I acknowledge personal information/claim information will also be released to relevant organizations in the event of an investigation etc.

Signature:	
Print Name:	Date: