ISM REHAB
INNOVATION SCIENCE & MEDICINE

Patient Intake Form

Last Name	First Name & Initial(s)	Date of Birth (dd/mm/yy)
Address	Street	Apt.
City	Province	Postal Code
Phone (home)/Phone(cell)		Email
Family Physician	Referring Physician ○ Same	
Emergency Contact Person	Relationship	Phone

Coverage: O No Coverage O Benefits O Motor Vehicle Accident

How did you hear about us?

O Doctor OWebpage O Social Media O Friend / Family O Google O Location O Other

Medical History (include date of onset):

O Pacemaker	O Lung Problems	O Viral Hepatitis
O Heart Problems	O Asthma	O Liver Disease (Fatty Liver)
O High Cholesterol	O HIV/AIDS	O Parkinson's Disease
O High Blood Pressure	O Chronic Fatigue/Fibromyalgia	O ADHD
O Stroke	O Thyroid Problems	O Allergies
O Osteoporosis/Osteopenia	O Skin Disease/Sensitivities	O Digestive Problems
O Cancer	O Epilepsy/Seizures	O Other_____
O Diabetes	O Anxiety	_____
O Currently Pregnant	O Depression	O Difficulty Sleeping at night

1) Do you currently smoke? ___ Yes ___ No
2) Do you drink alcohol? ___ Yes ___No If so, how many drinks do you consume a week? _____
3) Please list any surgeries (including internal pins/wires/artificial joints), past injuries or major dental work you've had

4) Please list your current medications (may also provide us a list of your current medications)

To the best of my knowledge, I certify that the information provided above is true and correct

_____	_____	_____
Name of Patient	**Signature**	**Date**