onetoone

# Interdisciplinary Intake Form

We recognize that some questions in this form may be sensitive. You have full control over what you choose to share with each provider. If there are questions you prefer not to answer in writing, you may leave them blank and discuss them directly with the team member you feel should be informed. Please note that if key health information is missing, our team may ask follow-up questions to ensure you receive appropriate, evidence-based care.

## General Information

Name: _____ Preferred Name (if different): _____

Pronouns: _____ Date of Birth: _____

Sex: _____ Gender: _____ Age: _____ Weight: _____ Height: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Emergency Contact: _____ Phone: _____

Best place to leave a message?: ☐ Home ☐ Work ☐ Cell ☐ Email

Employer: _____ Occupation: _____

Family Doctor: _____ Doctor Phone (if known): _____

Doctor Email (if known): _____

Referring Professional: _____ Phone (if known): _____

Email (if known): _____

How did you hear about us? _____

## General Health Information

Do you have any of the following health conditions (past or present)? Check off any that apply.

### Musculoskeletal Health

- ☐ Back Pain (Acute/Chronic)
- ☐ Ligament Sprains
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Scoliosis
- ☐ Joint Pain
- ☐ Muscle Strains
- ☐ Osteoporosis
- ☐ Sciatica
- ☐ Whiplash Injury

**Chronic Pain**

- [ ] Chronic Pain Syndrome
- [ ] Fibromyalgia
- [ ] Myofascial Pain Syndrome
- [ ] Pelvic Pain
- [ ] Complex Regional Pain Syndrome
- [ ] Migraines/Chronic Headaches
- [ ] Neuropathic Pain
- [ ]

**Mental Health Diagnosis**

- [ ] Anxiety Disorders
- [ ] Borderline Personality Disorder
- [ ] Eating Disorders
- [ ] Post-Traumatic Stress Syndrome (PTSD)
- [ ] Bipolar Disorder
- [ ] Depression
- [ ] Panic Disorders
- [ ] Sleep Disorders

**Chronic Conditions/Diseases**

- [ ] Asthma
- [ ] Cancer (Active or Remission)
- [ ] Chronic Fatigue Syndrome/Myalgic Encephalitis (CFS/ME)
- [ ] Chronic Obstructive Pulmonary Disease (COPD)
- [ ] Kidney Disease
- [ ] Thyroid Disorders (Hypo/Hyper)
- [ ] Autoimmune Disorders (e.g. Lupus, MS)
- [ ] Cardiovascular Disease
- [ ] Diabetes (Type 1 or Type 2)
- [ ] Irritable Bowel Syndrome (IBS)
- [ ] Stroke

**Trauma and Complex Disorders**

- [ ] ALS
- [ ] Ehlers Danlos/Hypermobility Syndromes
- [ ] Lyme Disease
- [ ] Post Orthostatic Tachycardia Syndrome (POTS)
- [ ] Chronic Inflammatory Conditions
- [ ] History of Trauma (Physical/Emotional)
- [ ] Concussion/Post-Concussion Syndrome
- [ ] Traumatic Brain Injury (TBI)

**Are you currently taking any medications? Please list all medications with current dosage.**

**Are you currently, or have you previously been prescribed, any of the following medication types?**

- [ ] Acetaminophen
- [ ] Anticonvulsants (e.g. Gabapentin/Pregabalin)
- [ ] NSAIDS
- [ ] Antidepressants
- [ ] Cannabinoids
- [ ] Opioids

**Have you had any surgeries in the past? Please list type and date.**

Do you have any known allergies? Please list all with known reaction.

Have you experienced any recent changes in your health (e.g. weight loss/gain, new symptoms)?

Have you experienced any falls, accidents, or injuries in the last 5 years? ☐ Yes ☐ No

Do you exercise regularly? ☐ Yes ☐ No

Regularly Enjoyed Activities (e.g. knitting, dancing, reading, tennis, video games)

Are you currently under a physician's care for any reason? ☐ Yes ☐ No

Do you have any concerns with your eating/nutrition habits? ☐ Yes ☐ No

Are you currently receiving care from other health professionals? ☐ Yes ☐ No

## Pain and Symptom Assessment

How would you rate your pain on a scale of 0 (no pain) to 10 (worst possible pain)?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Where is your pain located?

When did your pain or symptoms start?

What activities or movements worsen your pain or symptoms?

What activities or movements alleviate your pain or symptoms?

Have you experienced any recent flare-ups? If so, please describe triggers and duration.

## Psychological and Social Information

How would you describe your current mental health? (e.g. stress, anxiety, depression levels)

Do you have a support system (family, friends, etc.)?

How has your pain or your mental health impacted your daily life?

Are you currently seeing a mental health professional? (e.g. psychologist, counsellor, psychiatrist)

## Sleep Assessment

How many hours of sleep do you get each night? Circle the option that applies.

☐ 1-2 hours ☐ 2-4 hours ☐ 4-6 hours ☐ 6-8 hours ☐ 8+ hours

Do you have difficulty falling or staying asleep? ☐ Yes ☐ No ☐ Occasionally

Do you wake up feeling rested? ☐ Yes ☐ No ☐ Occasionally

Do you experience any of the following during sleep?

☐ Frequent Waking
☐ Nightmares
☐ Sleep Apnea
☐ Night Sweats
☐ Restless Leg Syndrome
☐ Snoring

## Goals and Expectations

What are your main goals of seeking treatment?

What are your expectations of our healthcare team?

Is there anything else you'd like us to know about you, your current health status, or treatment expectations?

# Consents

**Privacy Policy and Authorization**

One to One Wellness professionals collect personal information for the purpose of providing therapeutic treatment, safe training, useful information, and timely accounting. We add client contract details to our database to send newsletters, promotional offers, and other materials of interest. Clients may opt out of these services at any time by automated means or by contacting our administration team.

Our clinic adheres to high standards of confidentiality required by the Nova Scotia College of Physiotherapists. We use reasonable security safeguards to protect your personal information against loss, theft, or unauthorized access.

As a general rule, we only disclose information as instructed in writing by our clients. Circumstances of disclosure without consent are only those required by law, including review by professional regulatory bodies.
Yes, I authorize One to One Wellness Centre to collect and store my information as outlined above. I authorize the release of information pertaining to evaluation, treatment program, and progress to my medical doctor or other appointed professionals.

Signature: _____ Date: _____

**Payment Policy**

Payments are due at the time of service provision. If you would like us to bill your insurance company on your behalf, you must complete the Insurance Billing Agreement.

We cannot extend credit of any kind unless we have a credit card number on file and authorization to bill your account.

You are responsible for all charges not covered by your insurance company, including those for late cancellations or missed appointments.

Yes, I am aware of and agree to the terms of the Payment Policy.

Signature: _____ Date: _____

**24-Hour Cancellation Policy**

Your scheduled session is exclusively devoted to you. We require minimum 24 hours of notice if you are unable to attend your appointment. Failure to provide 24 hours will result in a Late Cancellation or No Show Charge. A 50% charge of the total appointment cost will result from your first late cancellation, and you may be charged 100% of the total appointment cost for all following instances. Please note these charges cannot be billed to an insurance company (e.g. Manulife, Blue Cross) and must be covered by you.
Yes, I am aware of and agree to the terms of the 24-Hour Cancellation Policy.

Signature: _____ Date: _____

**Insurance Billing Agreement**

At your request, we can bill directly for many insurance policies if the following criteria are met:
You accept responsibility for all charges not covered by your insurance company for any reason.
You provide a credit card number and authorize billing of charges not covered by insurance.
You accept responsibility for tracking the rules and limits of your coverage.

You affirm that you are seeking treatment for therapeutic purposes directed at a specific symptom, impairment, functional limitation, or disease.

You establish and periodically review goals, treatment plans, and discharge criteria with your therapist.
You consent to your doctor being notified that you are attending treatment.
Yes, I meet and agree to comply with these criteria and request direct billing to my insurance company.

Signature: _____ Date: _____

**Respectful Workplace Policy**

One to One Wellness is committed to providing a safe, health, and respectful environment for staff, patients, and visitors. At One to One Wellness, we strive to achieve the goals of creating a respectful workplace and providing extraordinary care and services that enhance public confidence. The expectation is that all staff, patients, support persons, and visitors:

- Treat each other with dignity, fairness, and respect
- Respect diversity, which includes both visible and invisible characteristics, and includes differences such as, but not limited to: age, life stage, ability, culture, ethnicity, sex, gender identity, geographical location, language, physical characteristics, race, religion, sexual orientation, socio-economic status, spirituality, and values.
- Communicate in a respectful manner
- Interact without any abuse, harassment, discrimination, aggression, or violence
- Report any inappropriate or unprofessional behaviour or conduct

If behaviours are witnessed that are in violation of the Respectful Workplace Policy, employees are permitted to discuss this policy with you and how it may be in violation of our policy, and/or you may be immediately discharged from our care.

Yes, I agree to the terms of the Respectful Workplace Policy.

Signature: _____ Date: _____