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PAIN MANAGEMENT CENTRE

FEM-AID APPLICATION

Please take a moment to fill out our intake form before your visit. All information is kept completely confidential.

First Name _____ Last Name _____

Preferred Name_____ Pronouns_____

Email _____ Mobile Phone_____

Street Address _____ Suite Number_____

City _____ Province_____

Postal / Zip _____ Country _____

Date of Birth_____

Gender (Refers to current gender which may be different than what is indicated on your insurance policies.)

_____

Sex (This field may be used for submitting claims to your insurance provider. Please ensure the sex you provide here matches what your insurance provider has on file.) _____

Emergency Contact

Name_____ Phone _____

Relationship _____

Family Doctor (if you have one)

Family Doctor Name_____ Family Doctor Phone_____

Family Doctor Email _____

Optional information (for our records)

Have any of your doctors recommended services we provide? If so, which services?

_____

How did you hear about us? _____

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Medical History

What are the main things you would like to address with treatments? You can list as many as you would like. Please also indicate how long you have had these issues.

_____

_____

Which conditions have been diagnosed by/treated by your doctor?

_____

_____

Do you have any previous or upcoming surgeries we should know about?

_____

Please provide any additional details related to your medical history.

_____

_____

_____

_____

Please list all of your current medications, including vitamins/supplements.

_____

_____

_____

_____

Please list all previous and current involvement of other healthcare professionals related to your health concerns (physician/provider and treatment provided).

_____

_____

_____

_____

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Please indicate where on the body you feel structural pain and when it started

_____

_____

Does anything make the pain better?

_____

_____

Does anything make it worse? (eg. stress, humidity, lack of sleep, intake of specific foods, etc)

_____

_____

Is there anything else we should know about today?

_____

<u>Pregnancies</u>

The following two questions are helpful for our intake process should you be accepted to the program. Please answer with complete honesty and to the best of your knowledge.

Are you currently pregnant? If yes, please indicate the number of weeks.

Yes No

Did you experience any of the following during pregnancy?

Pelvic pain

Back pain

Urinary incontinence

Vaginal heaviness

Postpartum depression or anxiety

Did you experience any problems/complications during postpartum recovery?

_____

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Gyneacological Health

When was the last time you had a PAP? If more than 5 years ago please indicate reason for delay

_____

Was your last PAP normal? (circle one)

Yes No

Financial Information

Please answer the following with complete honesty; there is no wrong or judgment.

Do you currently have private insurance available to you? (Circle one)

Yes No

Are you currently on any financial aid programs? (circle all that apply)

ODSP GAINS Other:

_____

Personal Statement

Please use the remainder of this page to tell us a little about yourself. It may be about what makes you a good fit for this program, something that makes you unique, or something you would like the world to know about you.

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Consent

Fem-Aid General Consent

I hereby certify that the information provided in this application is true and correct. I have used the information to the best of my knowledge to fully complete this application in hopes that I will be awarded a Fem-Aid Financial Assistance gift certificate. The grant entails a gift card in my name for the value of $200 which can be used against any number of, and any modality of, treatment that best suits my medical needs. This gift card has been graciously donated by an anonymous member of our community who wants to ensure others like myself are provided care when they cannot afford it and for this reason, if not for any other, I will be honest about the use of this gift card.

I understand the conditions and information provided above and give my consent to the above authorizations.

As such I consent to paying the balance of any balance incurred from these appointments beyond the $200 but will do my utmost to ensure the treatments fall within this budget.

Initials _____

I understand that I can give or withdraw consent at any point in time for a specific aspect(s) of the assessment or treatment - within a session and/or once the care plan has begun.

Initials _____

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with me 2 days after my appointment to check on any irregular side effects and to ensure these are documented in my file. All of the data that is provided in these forms are for the sole purpose of my care and will not be shared to any third party or with my family doctor.

Initials _____

Cancellation policy

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the therapists' day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee.

Initials _____

_____ _____

Patient signature Date