# Care X Us Clinic

***Dr. G Heffner, Dr. MN Arham, Dr. H Rubab***

## New Patient Intake Questionnaire Form

104-34143 Marshall Rd Abbotsford, BC V2S 1L8

Ph: 604-859-3982 Fax: 1-833-924-0386

PLEASE FILL OUT ALL PARTS TO THE BEST OF YOUR ABILITY:

Last Name:____________________________________ First Name:_______________________________

Care Card Number:_____________________Sexual Orientation: Male ◯ Female ◯ Other:______________

Marital Status:_________________________________Occupation:___________________________________

Date of Birth: D_________________M_____________Y______________Height:_________________Weight:________

Address:_______________________ City:__________________________ Postal Code:___________________

Email:_______________________________________________________________________

Home Phone:_________________________________ Cell Phone:___________________________________________

**Have you ever had a family physician? Yes ◯ No ◯ If so, please provide name and date last seen and contact information**:_______

____________________________________________________________________________________________________

____________________________________________________________________________________________________

Medical History:

Please tick any relevant medical history from below list

Asthma/Lung Disease ◯ Cancer ◯ Type:_________________ High Blood Pressure ◯ kidney disease ◯

Chronic Pain ◯ Anxiety/Depression/Mental Health ◯ Arthritis ◯ Diabetes ◯ Cardiac ◯ Liver Disease ◯ Stroke ◯

Thyroid Disease ◯

Please list any other relevant medical conditions not listed above:_______________________________________________

____________________________________________________________________________________________________

____________________________________________________________________________________________________

Previous Surgeries:__________________________________________________________________________________

___________________________________________________________________________Allergies:_____________________

____________________________________________________________________

Smoker: Y ◯ N ◯ If yes how many per day/week:__________________________ For how long: _________________

Alcohol: Y ◯ N ◯ If yes how many per day/week:__________________________For how long: _________________

Recreational Drugs? Y ◯ N ◯ If yes please note:___________________________________

Do you take any opioid pain medications i.e. Morphine, Hydromorphone, Oxycodone, Codeine, Tylenol # 3, Fentanyl etc.? Yes ◯ No ◯ **If yes, please list** _____________________________________________________________________________

____________________________________________________________________________________________________

Do you take any Benzodiazepine's i.e. Ativan, Lorazepam, Clonazepam, Diazepam, Valium, Alprazolam, Xanax, etc.? **If yes, please list**__

______________________________________________________________________

______________________________________________________________________

Please list **ALL** Medications and how often they are taken:______________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Are there any other medications you used to take regularly, but have stopped in the last year?

______________________________________________________________

Do you have any pending ICBC/WCB claims (Please note Claim number and Date of Injury/Accident:______________

______________________________________________________________________

______________________________________________________________________

Do you have extended medical coverage: Yes ◯ No ◯

Do you have extended medical coverage for Physiotherapy, Chiropractic, Massage Therapy etc.? Yes ◯ No ◯

Are you on any kind of disability: Yes ◯ No ◯

Any Hospitalization or ER visit in last 12 months: Y ◯ N ◯ When and Why: ______________________________

FOR FEMALE PATIENTS ONLY:

Date of Last Menstrual Period:____________ Date of Last Pap Smear:__________History of Abnormal Pap: Y ◯ N ◯ Please list date:_______________________Date of Last Mammogram:_______________Date of last FIT test:________________ Date of last Colonoscopy:_____________ Are you using any Birth Control: Y ◯ N ◯ Details:__________________________

For Male Patients Only:

Date of Last Fit test:______________Date Of last Colonoscopy:________________ Date of last PSA:___________________

I have Read and understand all the above information and have answered the questions accurately and honestly to the best of my ability. ****Please note new patients that no show to their first appointment will not be able to re-book****

Signature:____________________________________________

Date:_______________________________________________

****PLEASE DO NOT CONTACT US****

**PATIENTS WHO HAVE BEEN ACCEPTED WILL BE CONTACT BY OUR OFFICE**

# ***CareXus Clinic Policy:***

**Chronic Pain:**

**Doctors are not in favor of prescription Opioids, and Narcotics for chronic pain management other than non-cancerous pain because of its More long-term Harm then benefits.**

**Opioids Medications**

**Opioids are strong pain medications such as Codeine, Morphine, Oxycodone, etc. Even Tylenol #3's are an opioid medication (they contain codeine). Doctors at CareXus Clinic follow modern day guidelines regarding chronic pain. Specifically, opioids are not indicated for chronic non-cancer pain.**

**More and more studies show they do not help in the long term, and only cause side effects and harm. When it comes to chronic pain, we highly suggest things like non-medication treatments such as physiotherapy, exercise, massage, yoga, meditation, etc. There are medications like Tylenol, anti-inflammatories, *maybe muscle relaxers* or other non-opioid medications (like Cymbalta, Lyrica, Gabapentin, and others).**

**Benzodiazepine Medications**

**In keeping with modern day guidelines, Doctors does not prescribe long term benzodiazepine medications (i.e. Ativan, Valium, etc.). They cause more harm than good in the long run.**

**I have read and accept all the above.**

**Yes ◯ No ◯**

**Signature:____________________________Date:____________________**

**TO BE VERY CLEAR, EVEN IF YOU ARE CURRENTLY TAKING AN OPIOID MEDICATION FOR CHRONIC PAIN, Doctors at CareXus Clinic WILL NOT AGREE TO KEEP PRESCRIBING IT FOR YOU. Instead, the plan will be to ween you off your opioid medications, and instead rely on all the other proven options for treating chronic pain. You may have had different experiences with other doctors in the past. If you are expecting a different approach from your Family Doctor, then Doctors at CareXus Clinic may not be the best doctor for you.**

**I have read and accept all the above.**

**Yes ◯ No ◯**

**Signature:____________________________Date:____________________**

## Thank you for your understanding

## -Care X Us Clinic

Ministry of Health



# PHARMANET
# Patient Consent to Access PharmaNet

The Province of British Columbia has established the provincial pharmacy network and database known as "PharmaNet" pursuant to section 37 of the *Pharmacists, Pharmacy Operations and Drug Scheduling Act,* R.S.B.C. 1996, c. 363, and which may be continued pursuant to section 13 of the *Pharmacy Operations and Drugs Schedule Act,* S.B.C., 2003, c. 77 should it be proclaimed in force during the term of this Agreement.

I, ________________________________, authorize ____________________
*Name of Patient (print)* *Name of Physician (print)*

and persons directly supervised by him/her to access my personal health information contained within PharmaNet for the purpose of providing therapeutic treatment or care to me, or for the purpose of monitoring drug use by me.

I understand that withdrawal of this consent must be in writing and delivered to the above-named physician.

Executed at _________________________, this _______ day of _______________, 20____.

SIGNED AND DELIVERED by )

______________________________________ )
*Patient (print)* )

in the presence of: )

______________________________________ ) ____________________________
*Witness (signature)* ) *Patient (signature)*

______________________________________ )
*Witness (print)* )

______________________________________ )
*(Dated)* )