PHYSIOCARE PHYSIOTHERAPY & REHAB CENTRE

Patient Intake Form

Last name _____ First name & initial(s) _____ D.O.B (yyyy/mm/dd) _____

Address _____ City/Province _____ Postal Code _____

Phone (home) _____ Phone (mobile) _____ Phone (work) _____

Patient's Email _____ Emergency contact (name & phone) _____

Family Doctor (name & contact information)

_____

Referring Doctor (If different than family doctor)

_____

Insurance Company #1 _____ #2 _____

Policy 1 # _____ ID # _____

Policy 2 # _____ ID # _____

How did you hear about us?

[ ] website [ ] street signage [ ] family/friend referral _____

[ ] facebook [ ] local businesses [ ] Flyer [ ] Billboard

[ ] Google [ ] Others _____

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Physiocare policies

1. Please provide 24hours notice of cancellation for your appointment otherwise a **fee of CAD 25** will be charged. A same day cancellation or no show will result in **full appointment charge**.
2. Late arrivals will be seen for the remainder of their appointment time only. It is our goal to stay on schedule to the best of our abilities.
3. Payment is due in full at the end of each treatment session. Payments will be accepted by cash, cheque, debit, or credit card, and a receipt will be provided for reimbursement by your insurance company after each visit.
4. We do not accept tips under any circumstances.
5. If your visit is as a result of a **motor vehicle accident**, please provide all necessary information to our staff before your appointment. This includes your private insurance information, adjuster contact info, claim number & driver's license.

I understand and agree with, the above listed criteria under Physiocare policies

_____ _____

Patient signature (parent/guardian if under 18) Date

Release of Medical Information

Your privacy is of the utmost importance to us. The info collected in this intake form will assist us in treating you safely. All info provided will be kept confidential unless by the request of the patient to distribute, or required by law. Your written permission is required in order to release any of your treatment details, and for us to obtain information, from your previous/current health care providers.

I authorize Physiocare to release my physiotherapy/massage records to, and to obtain medical /health records from all practitioners concerned with my care.

_____ _____

Patient signature (parent/guardian if under 18) Date

Consent to communicate via email

I authorize Physiocare physiotherapy & Rehab Centre to contact me via email to remind me for my appointment(s) and for any communication on scheduling.

_____ _____

Patient signature (parent/guardian if under 18) Date

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Consent to assessment and treatment

Assessment and treatment at Physiocare may include, but is not limited to: manual therapy techniques, spinal manipulation, electrotherapeutic modalities, acupuncture, registered massage therapy, and exercise. It is the policy of Physiocare Physiotherapy & Rehab Centre to ensure that each patient is educated about the benefits, side effects, and potential complications of each of the treatment modalities used by our therapists to decrease symptoms, and improve function, before use.

If you have any questions or concerns about any of your recommended treatments, you must inform your healthcare provider immediately, so they can explain the treatment rationale and/or modify your program accordingly. If at any time you may choose not to participate in any type of treatment, you must inform your healthcare provider immediately.

I understand and agree with the above criteria and, in compliance with the "Consent to Treatment Act" Bill 109, voluntarily consent to participate in an assessment and treatment program at Physiocare Physiotherapy & Rehab Centre

I understand that my consent may be withdrawn at any time during my treatment after informing my healthcare provider at Physiocare and that I may stop or alter my physiotherapy/massage therapy treatment at any time.

I, _____, of my own free will consent to be treated

for the following injuries/complaint(s):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

_____ _____

Patient signature (parent/guardian if under 18) Date

General Medical History

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CARDIOVASCULAR

□ High blood pressure

□ Low blood pressure

□ Congestive heart failure

□ Heart attack

□ Stroke/CVA

□ Phlebitis/varicose veins

□ Heart disease

□ Pacemaker or similar device(s)

RESPIRATORY

□ Chronic cough

□ Shortness of breath

□ Bronchitis □ Asthma

□ Emphysema

COMMUNICABLE DISEASES

□ Hepatitis □ Skin conditions
□ TB □ HIV/AIDS

□ Communicable diseases or hemophilia? Please describe

_____

_____

BONE HEALTH

History of Fractures:

○ Yes ○ No

if yes, please describe:
_____

Osteoporosis/Osteopenia

○ Yes ○ No

Date of last bone density scan: _____

Arthritis ○ Yes ○ No

Onset/type: _____

DIABETES ○ Yes ○ No

Onset/type:
_____

EPILEPSY ○ Yes ○ No

CANCER ○ Yes ○ No
Onset/type/current state:
_____

Is there a **family history** of any of the above conditions? If yes, please describe:
_____

_____

HEAD/NECK

□ History of headaches

□ History of migraines/ new onset?

□ Vision loss/changes

□ Dizziness/Double vision

□ Hearing loss/ear condition(s)

PELVIC HEALTH
Are you currently Pregnant?
○ Yes ○ No ○ n/a
Due date: _____
# of prior pregnancies ____

Have you experienced any changes to your bladder/bowel function? ○ Yes ○ No
If yes, please describe:
_____

Other Condition(s)

□ Allergies/hypersensitivity? □ Mental health □ Digestive Conditions □ Organ dysfunction

□ Not listed above?
If so, please list here:
_____

_____

Patient's name: _____

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Medications

Current Medication(s)

(please feel free to provide a copy of any medication lists instead)

1.	2.
3.	4.
5.	6.
7.	8.
9.	10.

Please list any previous **surgical procedures** and any details/**hardware (**e.g. prosthesis, wires, internal pins/fixators/rods, replaced joints)

_____

_____

Please list the names and contact information of **other practitioners** that are participating in your care, that you would like us to communicate with.

_____

_____