Intake Form

Patient Information		
Date: DD/MM/YYYY		
First Name:	**Last Name**:	**Middle Initial:**
☐ Male ☐ Female		
Email Address:		
Address:		
City		
Province:		
Postal Code:		
Birth date : DD/MM/YYYY		
Cell Phone#:		
Home Phone #:		
Referred to Clinic By: Insurance Plan	Family	Friend
Doctor	Close to Work/Home	Website
Yellow Pages	Street Sign	Other
CARE PROVIDER INFORMATION		
Referring Dr:	Phone:	
Family Physician**:**		
INSURANCE INFORMATION		
Primary Insurance Name:		
Name of policy holder:	**DOB:**	
Plan#:	**ID. #:**	
Patient's Relationship to Policy Holder: Self Spouse Child Other		
Name of Secondary Insurance:		
Name of policy holder:		
Plan#:	**ID. # :**	
Patient's Relationship to Policy Holder: Self Spouse Child Other		
IN CASE OF EMERGENCY		
Name of Local the Person:		
Relationship to Patient:		
Phone# :		

PAST MEDICAL HISTORY FORM

HEART DISEASE	YES	NO
Heart Attack	○	○
Atherosclerotic	○	○
Myocardial Infarction	○	○
Murmur	○	○
Do you have a pacemaker	○	○

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	○	○
Rheumatoid Arthritis	○	○
Multiple Sclerosis	○	○
Epilepsy	○	○
Gout	○	○
Fibromyalgia	○	○
Diabetes	○	○

LUNGS	YES	NO
Asthma	○	○
Emphysema	○	○
Shortness of Breath	○	○

List all medications you are currently taking: ____

List all surgeries in the past two years (Including dates):

Are you Pregnant? ○ Yes ○ No If so, what week are you in?

Painful Body Areas : ____

Have you had any injuries related to work? ○ Yes ○ No

If yes, list body part ____________________ Date of Injury : __________________________

Have you had any Auto Accidents ○ Yes ○ No

If yes, list body part ____________________ Date of Injury :__________________________

Have you had Physical Therapy or Massage Therapy before? ○ Yes ○ No

Physiotherapy Informed Consent for Assessment and Treatment

I, undersigned, do hereby give my voluntary consent for the administration of Physiotherapy deemed appropriate by my treating Physiotherapist. I understand that Physiotherapy treatments may include an individualized exercise prescription and various forms of manual therapy techniques such as mobilization, manipulation, soft tissue release and stretches. Treatments may also include modalities such as heat, ice, therapeutic taping, ultrasound, laser, TENS, interferential current, shock wave and electric muscular stimulation. Other treatment options include acupuncture/dry needling, that involve the insertion of single use, sterile, disposable needles through the skin, into the underlying muscles. I understand that the primary goals of Physiotherapy treatments are to help reduce my pain and improve my mobility, strength, endurance, function and quality of life. I understand that there are very small possibilities of risks or complications that may result from the above listed treatments. I do not expect the Physiotherapist to anticipate all the possible risks and complications. I wish to rely on the Physiotherapist to exercise proper judgment during the course of treatment to make decisions based upon my best interest.

Potential small but possible risk factors:

Manual therapy: Joint and/or muscle soreness

Exercise therapy: Joint and/or muscle soreness

Electrical modalities: Minor skin irritations such as redness or rash

Acupuncture/Dry Needling: Minor soreness, bleeding or bruising, nausea, fainting, infection, shock convulsions, possible perforation of internal organs, stuck or bend needles, and fetal distress in pregnant women.

I will immediately notify the Physiotherapist of any changes in my pregnancy or medical status. I will have the opportunity to discuss with my Physiotherapy the nature and purposes of all my treatments. I accept the fact that there is no guarantee of the effectiveness of the treatment. I am aware that I may withdraw this consent and discontinue treatment at anytime. I consent to the Physiotherapy treatments offered or recommended to me by my Physiotherapist(s). I intend this consent to apply to all my present and future Physiotherapy care

____________________	____________________	____________________
Date	Patient Name	Patient Signature

Cancellation Policy

We ask that you provide 24 hours notice of cancellation for any appointments.

We reserve the right to charge of $25 for any appointment that are missed without notice.

Thank you for your agreement

Date :___________________

Name:___________________

Signature:________________

Witness:__________________