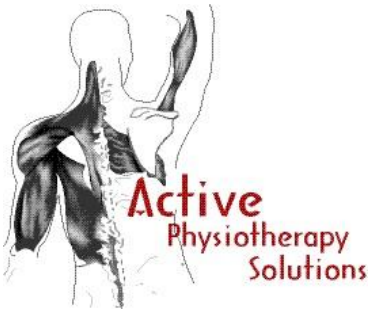

GENERAL CLIENT INFORMATION

(Please print)

NAME: _____ DATE OF BIRTH: _____/_____/_____ (DAY/MTH/YR)

ADDRESS: _____
Street # City Province

POSTAL CODE: _____

EMAIL:
_____

PHONES: (Home) _____ (Cell) _____

(Work) _____

FAMILY DOCTOR: _____ REFERRING DOCTOR: _____

HOW DID YOU FIND OUT ABOUT US?

☐ Yellow Pages ☐ Website ☐ Word of Mouth ☐ Friends/Family ☐ Family Doctor
☐ Hospital ☐ Signage ☐ Insurance Company ☐ Advertising
☐ Other_____

Our Client Referral Program

Were you referred by a friend or family member?

If so, please let us know their name:

_____

Ask how you can participate!

FOR ALL CLIENTS, TREATMENTS MUST BE PAID IN FULL AT EACH VISIT.

Consent to Assessment and Treatment

Assessment and treatment at Active Physiotherapy Solutions 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 Active Physiotherapy Solutions 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 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 Active Physiotherapy Solutions.

I understand that my consent may be withdrawn at any time during my treatment after informing my healthcare provider at Active Physiotherapy Solutions, and that I may stop or alter my physiotherapy therapy treatment at any time.

I, _____, consent to be treated for my injuries.

_____ _____

Patient Signature (parent/guardian if under 16) date

Client Intake Policies

1. Please provide 24 hours notice of cancellation for your appointment. A fee will be charged to your account if you do not show up for your appointment or if you choose to cancel within 24 hours of your appointment time.

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, debit, cheque or credit card, and a receipt will be provided for reimbursement by your insurance company after each visit.

4. If your visit is as a result of a motor vehicle accident or WSIB claim, please provide all necessary information to our staff before your appointment. This includes your private insurance information (if applicable), adjuster contact information, and claim number.

I understand, and agree with, the criteria listed under Active Physiotherapy Solutions intake policies.

_____ _____

Patient Signature Date
(Parent/Guardian if under 16)

Release of Personal and Medical Information

Your privacy is of the utmost importance to us. The information collected in this intake form will assist us in treating you safely. All information provided will be kept in confidence 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 or personal information, and for us to obtain information, from your previous/current health care providers or your benefit providers.

I authorize Active Physiotherapy Solutions to release my physiotherapy records to, and obtain medical /health records from, all practitioners or benefit providers or other providers concerned with my care.

_____ _____

Patient Signature Date
(Parent/Guardian if under 16)

GENERAL HEALTH QUESTIONNAIRE

Occupation _____ Job Duties_____

To ensure safe and appropriate treatment programs, please indicate which of the following apply to your general health:

- ❑ Arthritis (Osteo/Rheumatoid)
- ❑ Diabetes (Type I /Type II)
- ❑ Osteoporosis
- ❑ History of Cancer
- ❑ Heart Disease
- ❑ Pacemaker
- ❑ High/Low Blood Pressure
- ❑ Chest Pain
- ❑ High Cholesterol
- ❑ Asthma/Breathing Difficulties
- ❑ Shortness of Breath
- ❑ Blood Disorders
- ❑ Thyroid Problems (Hypo/Hyper)
- ❑ Epilepsy
- ❑ Metal Implants
- ❑ Pregnancy
- ❑ Recent/Unexplained Weight Loss/Gain
- ❑ Hearing Difficulty
- ❑ Vision Problems
- ❑ Double Vision
- ❑ Difficulty Speaking
- ❑ Difficulty Swallowing
- ❑ Dizziness
- ❑ History of Falls
- ❑ Balance Difficulties
- ❑ Groin Numbness/Tingling
- ❑ Memory Problems
- ❑ Anxiety
- ❑ Depression

Other _____

Recent Surgeries: _____
_____

Is there anything else we should know about your health**?** _____
_____

Recent Injections: □ No □Yes _____

Medications:

Name	Dose	How often?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you had any of the following investigations recently?

	Date	Location
❑ X-ray	_____	_____
❑ CT Scan	_____	_____
❑ MRI	_____	_____
❑ Ultrasound	_____	_____
❑ Nerve Conduction Test/EMG	_____	_____

Date: _____ Signature**:** _____