ACTIVE APPROACH Health & Wellness Centre

New Patient Form (Physiotherapy)

□ Mr. □ Mrs. □ Miss □ Ms. □ Dr.

First Name: _____ Last Name: _____

Date of Birth: Month_____ Day_____ Year_____

Gender: F □ M □

Street Address:_____ Apt.#:_____

City:_____ Province:_____ Postal Code: _____

Email:_____

Phone: Home: _____ □
Work: _____ □
Cell: _____ □

Please check if we can leave a message or reminder call at that number

Reminders: □ Text □ Phone □ Email

Occupation_____ Company:_____

Emergency Contact:_____ Phone:_____

Do you have extended health care insurance? Yes or No

If so, which insurance company?_____

How did you hear about us? _____

How long have you had the particular injury/condition that has brought you to our office?

_____

What is this injury/condition preventing you from doing?_____

_____

What have you tried in the past to treat this injury/condition?_____

_____

Family Physician's name: _____

Family Physician's telephone: _____MSI #: _____ Exp:_____

Previous Imaging? (X-Ray/CT Scan/MRI):_____

Body Region Imaged:_____

Date of Imaging:_____

Location Imaging Taken: _____

Previous Physiotherapy Treatment N/A □

Previous physiotherapist's name:_____

Date of last physiotherapy visit:_____

Please be advised that your health information will be shared only with the authorized practitioners providing treatment to you.

Please Turn Over

Type of Injury

Are your injuries related to a motor vehicle case? Yes ☐ No ☐

(*If yes, please fill in the following information*)

Date of accident: _____

Insurer's name: _____

Policy or claim number: _____

Insurer's address and telephone: _____

PLEASE NOTE, WE DO NOT ACCEPT WORKER'S COMPENSATION BOARD CLAIMS.

Cancellation Policy

Twenty-four (24) hours notice, outside of illness, emergency, or severe weather conditions, is required for cancelling or rescheduling appointments. A fee of 100% of the treatment may be payable on the cancellations without adequate notice and "no-shows".

Consent

I have read the above, and agree and understand that I am responsible for all charges relating to my visit.

Date: _____ Signature: _____

Patient/Guardian if patient is under 18 years of age

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MEDICAL HISTORY INFORMATION Name: _____

Please indicate any of the following conditions that **you** have:

- ❒ Arthritis
- ❒ Hernia
- ❒ Diabetes
- ❒ Depression
- ❒ Thyroid Condition
- ❒ Osteoporosis
- ❒ Dizziness/Fainting
- ❒ Smoking History
- ❒ Low/ High Blood Pressure
- ❒ Reynaud's
- ❒ Heart Condition
- ❒ Sleeping Problems
- ❒ Chest Pain
- ❒ Cough
- ❒ Pacemaker
- ❒ Vision Difficulties
- ❒ History of Cancer
- ❒ Swallowing Difficulties
- ❒ Allergies to tape/latex
- ❒ Slurred Speech
- ❒ Any Allergies
- ❒ Memory Problems
- ❒ Epilepsy/Seizures
- ❒ Balance Problems
- ❒ Shortness of Breath
- ❒ Recent Falls/Blackouts
- ❒ Asthma
- ❒ Unexplained Weight Loss
- ❒ Bronchitis
- ❒ Groin Numbness/Tingling
- ❒ Other Respiratory Condition
- ❒ Bowel & Bladder Difficulties
- ❒ Hearing Impairment
- ❒ Headaches
- ❒ Pregnancy
- ❒ Blood Diseases
- ❒ Metal Implants (incl. IUD)
- ❒ Other:

Past Surgeries or Injuries: (please list with dates)

_____

_____

_____

Injections: (please list with dates)

_____

_____

- Is there anything else we should know about your health?

  _____

  _____

- Do you have a return appointment with the doctor who referred you? □ YES □ NO
  If yes, when?

  _____

- What do you expect/hope to achieve from therapy?

  _____

- Are you presently receiving or have you ever received any of the following treatment for your current problem?

□ Chiropractic □ Massage □ Occupational Therapy □ Naturopathic

□ Reflexology □ Acupuncture □ Physiotherapy □ Podiatry

Please Turn Over

SYMPTOM DIAGRAM

Please indicate (using the symbols) the areas on your body that you feel best represent the pain(s) or sensation(s) you are experiencing:

Numbness: _____ _____ _____

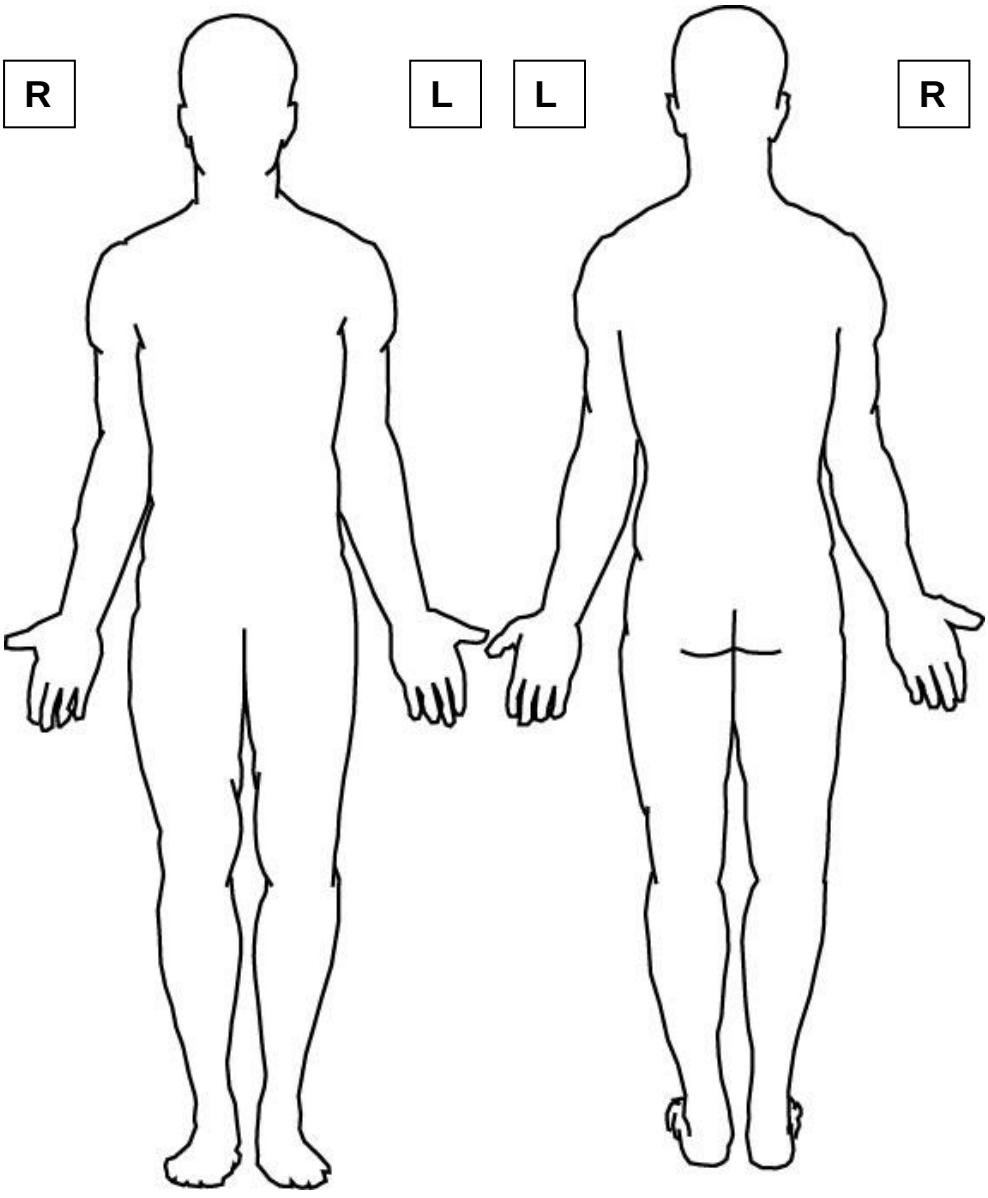
Burning: x x x x x x x x x x x x x x x

Pins & Needles: . . . .

Stabbing / Sharp: / / / / / / / / / / / / / / / /

Dull & Aching: + + + + + + + + + + + + + + +

Stiff & Tight: T T T T T T T T T T T T T T T



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