PHYSIOTHERAPY INTAKE FORM – EHC

Family name: _____ First name: _____

Address: _____ Home Telephone: (___)_____

City: _____ Work Telephone: (___)_____ Cell: (___)_____

Postal Code: _____ Date of Birth: ___/___/___ Email address: _____

mm/dd/yy

Family Doctor: _____ Telephone#: _____

How did you hear about us? (Please circle) Doctor | Friend | Gym/Walk-In | Sign / Internet

Name of Doctor referred by:_____ or Friend Name: _____

Extended Health Care Information:

Primary Insurance Co: _____Insured (Policy Holder): _____ DOB:_____

Employer: _____Policy/Plan #_____Certificate/ID#_____

Secondary Insurance Co._____Insured (Policy Holder)_____ DOB:_____

Employer:_____ Policy/Plan #_____ Certificate/ID #_____

*through a spouse or parent – need a birth date of the policy holder

CONSENT FOR MEDICAL RELEASE

I _____consent and authorize CFNAC Physio to obtain from and release to, my doctor, hospital or other health care provider any and all relevant information related to my medical condition.

Signature: _____ Date: _____

CONSENT FOR TREATMENT

I agree to participate in a physiotherapy assessment at your centre; based on my discussion with my therapist after their assessment of my condition, I agree to participate in a suitable rehabilitation program. I understand that my program will consist of treatments from various rehabilitation professionals and will include one or more of the following services: Physiotherapy, Exercise therapy, Acupuncture, Massage therapy, Functional Abilities Assessment.

I understand that the services will be provided, as they are deemed necessary by the appropriate health practitioner and/or my family physician. I agree to provide the centre with all relevant information regarding my condition. I understand that it is my responsibility to inform my treating health practitioner if I feel that any activity puts me at risk for injury.

I hereby consent to the treatment as described above.

_____ _____

Date Signature

Clinical Policies

-Extended Health Care-

Payment

CFNAC Physiotherapy will attempt to contact your Insurance Company to confirm your plan coverage prior to commencing treatment.

Payment Options Available: Cash, Debit, Visa, MC, or Personal cheques.

OPTION 1:

Provide payment at time of treatment. CFNAC Physiotherapy will provide you with an invoice so that you may submit your claim directly to your insurance company for reimbursement.

OPTION 2:

With some insurance plans, CFNAC Physiotherapy can bill your insurance directly.

I hereby acknowledge that I am personally liable to CFNAC Physiotherapy for the payment of the professional services provided by this clinic. I further undertake and agree to endorse and forward forthwith to CFNAC Physiotherapy any and all monies received by me from my Insurance Company in respect of payment for those services. If payment is not made to CFNAC Physiotherapy within 45 days of treatment, CFNAC Physiotherapy may bill your credit card.

Cancellation, Lateness or Absenteeism

If you need to change or cancel your appointment time, we ask for your consideration in providing at least 24 hours notice. You may call anytime, as our answering machine will receive messages when no one is available. **CFNAC Physiotherapy reserves the right to impose a $30 fee to anyone who cancels last minute or misses their scheduled appointment without notifying the office.**

Clients who arrive late for their scheduled appointment cannot be guaranteed to be accommodated. Every effort will be made to provide the required treatment in a timely manner. Alternatively, another appointment may have to be scheduled.

Clients who do not show up for 3 scheduled appointments may be discharged from therapy**.**

I fully understand and agree to abide by CFNAC Physiotherapy policies as outlined above.

Name (please print) _____ Date_____

Signature_____

Physiotherapy Questionnaire

Name_____

Occupation_____

Are you currently:-

Working ☐ Performing modified duties ☐

Off work ☐ Retired Other☐_____

Are you:-

Right handed ☐ Left handed ☐

Do you have help at home? ☐Yes ☐No

Pre-injury activities:-

Sports/hobbies_____

Household tasks_____

Outdoor tasks

Medical Information

Family Physician_____

Specialist_____

Date of injury/onset_____

Date of surgery (if applicable) _____

Has any diagnostic testing been done (x-ray, CT scan , etc)?_____

_____

_____

List all medications you are currently taking:-

_____

_____

_____

_____

_____

_____

General Health

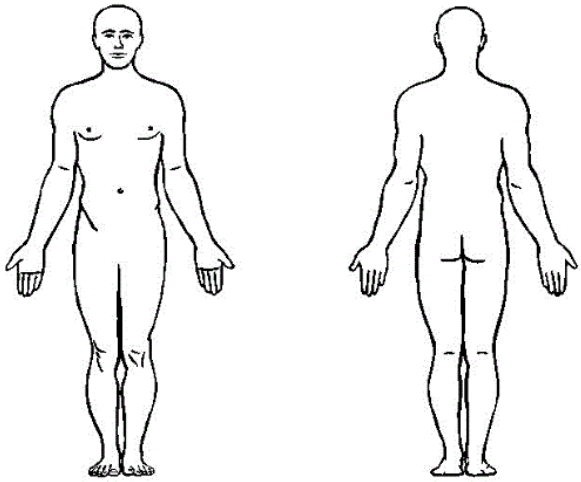
Do you smoke?	☐Yes ☐No
Do you have diabetes?	☐Yes ☐No
Do you have a heart problem?	☐Yes ☐No
Do you have epilepsy?	☐Yes ☐No
Do you have high blood pressure?	☐Yes ☐No
Have you ever had cancer?	☐Yes ☐No
Any recent sudden weight loss?	☐Yes ☐No
Do you have circulation problems?	☐Yes ☐No
Any bowel or bladder problems?	☐Yes ☐No
Are you pregnant?	☐Yes ☐No
Have you had recent surgery?	☐Yes ☐No

Describe any other health problems:-

_____

_____

Indicate the location, type (dull, sharp, ache etc.) and intensity of your pain (out of 10):



What do you hope to gain from your physiotherapy treatments?

_____

_____