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:** _____

CONSENT FOR MEDICAL RELEASE

I _____ consent and authorize **CFNAC Physiotherapy for Performance** to obtain from and release to, my doctor, or other health care provider any and all information pertaining and relevant to my medical condition and reason for physiotherapy treatment.

Signature: _____ **Date**: _____

CONSENT FOR ASSESSMENT AND TREATMENT

I _____ consent and agree to a physiotherapy assessment at CFNAC. Based on my discussion with my therapist during and after the assessment, I consent and agree to participate in physiotherapy treatment. I am aware that each physiotherapy treatment session will also include education regarding the treatment recommendations and consent discussed prior to any treatment. This may include modalities such as acupuncture/ dry needling, manual therapy and manipulation modalities, pelvic health physiotherapy, and exercise prescription. Specific consent will be requested at the time of all and any re-assessment and treatment.

I understand that my physiotherapy treatment may include exercise prescription and supervision by a delegated coach and/ or assistant of the CFNAC team. I agree to provide CFNAC physiotherapy with all relevant information regarding my condition. I understand that it is my responsibility to inform my physiotherapy team if I feel that any activity puts me at risk for injury.

I hereby consent to the treatment as described above.

Signature: _____ **Date**: _____

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Clinical Policies

Extended Health Care

Payment Options

Payment must be provided at the time of assessment/ treatment. Payment methods accepted include cash, debit, Visa and MasterCard.

A detailed receipt, including all information required to submit for extended health insurance reimbursement will be emailed to you with each physiotherapy appointment.

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 by calling CFNAC or contacting your physiotherapy team member. ***CFNAC reserves the right to impose a $60 fee to any patient cancelling last minute or misses a scheduled appointment without timely notification.***

Patients arriving late for their scheduled appointment cannot be guaranteed to be accommodated. Every effort will be made to provide the required assessment/ treatment in a timely manner. Alternatively, another appointment may need to be scheduled.

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

Signature: _____ **Date**: _____

Privacy Policy

The Physiotherapy program at CFNAC prioritizes the importance of protecting the privacy and personal information of our clients and patients at all times. We are committed to collecting, using and disclosing personal information responsibly and only to the extent necessary for the goods and services we provide. A complete outline of our privacy policy is available upon request. If you have questions or concerns regarding our privacy practices, please feel free to contact our privacy Officer:

Jennifer Bladon
jen@betterthanfit.com
905-895-4461

PHYSIOTHERAPY INTAKE FORM EHC

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

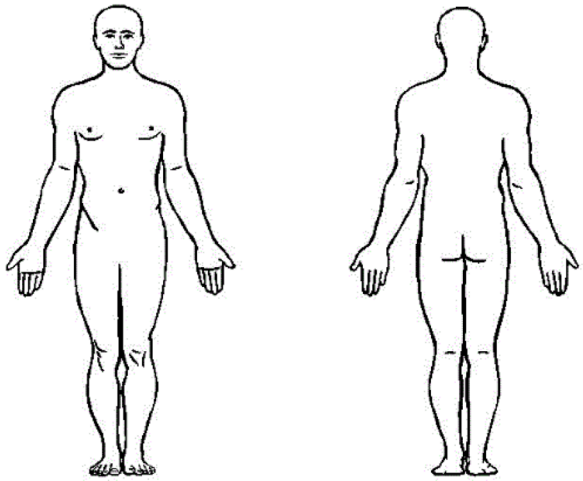
Describe any other health problems

_____

_____

_____

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?

_____

_____