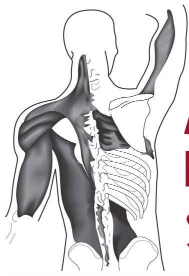

Active
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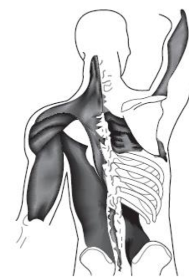

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GENERAL CLIENT INFORMATION

(Please print)

NAME: ________________________________ DATE OF BIRTH: ______/______/______ (DAY/MTH/YR)

ADDRESS: ____
Street # City Province

POSTAL CODE: ________________

EMAIL: ____ Permission to receive emails: __________

PHONES: (Home) ______________________________ (Cell) _________________________________

(Work) ______________________________

FAMILY DOCTOR: _________________________ REFERRING DOCTOR: ___________________________

WHY IS IT IMPORTANT TO YOU THAT YOU GET RID OF YOUR INJURY/PROBLEM AS SOON AS POSSIBLE?

____

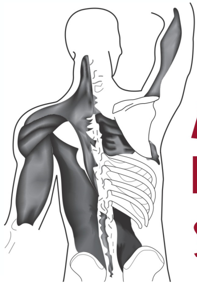
WHAT ARE THE TWO MAIN THINGS YOU WOULD LIKE TO ACHIEVE BY THE END OF TODAY'S SESSION?

1) ____ 2) ____

HOW DID YOU FIND OUT ABOUT US?

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

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



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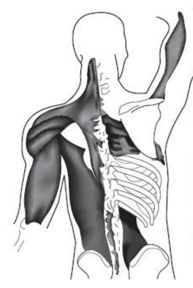

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Consent to Assessment and Treatment

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.

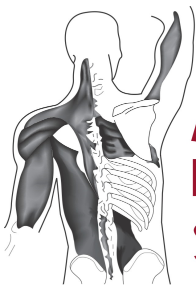
I understand and agree with the above criteria and, in compliance with the "Consent to Treatment Act" Bill 109, voluntarily consent to participate in an assessment and treatment program at Active Physiotherapy Solutions.

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.

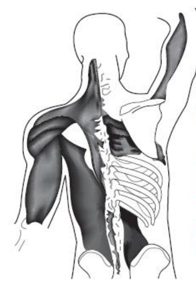
I, ___________________________________, consent to be treated for my injuries.

____ ___________

Patient Signature (parent/guardian if under 16) date



Client Intake Policies



1. **Please provide 24 hours notice of cancellation for your appointment**.
A **$50** 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 _________________________________

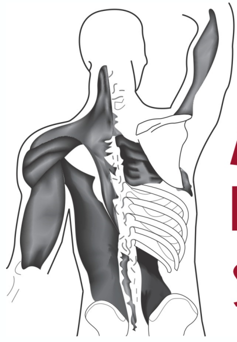
Medications:

Name	Dose	How often?

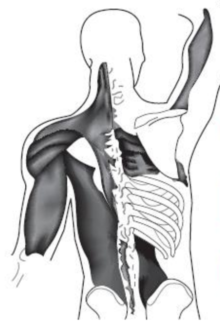
Have you had any of the following investigations recently?

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

Date: ____________ Signature: ____



Active Physiotherapy Solutions



Woodstock Physiotherapy Clinic

Our commitment is to:

- Provide a friendly, warm and calming atmosphere
- Provide supportive, motivating staff you can trust at all times
- Listen with respect to your needs and concerns
- Work actively with you to reach your goals
- Explain your condition and treatment plan clearly and concisely
- Answer any questions that you have
- Attempt to accommodate your scheduling needs
- Children are welcome to attend appointments if necessary, but you must supervise them.
- Provide cheque, cash, MasterCard, Visa and debit payment services

We appreciate your commitment to:

- Be on time, attend appointments as recommended
- Pay for treatment visits at each appointment, a receipt is provided for you to submit to Extended Health Care Providers if applicable
- Please provide 24 hours' notice in case of cancellation (a **$50** charge is applied otherwise) Phone call or email is acceptable
- Perform exercise program and follow advice of your physiotherapist
- Talk to us, let us know what you think, definitely ask questions
- Take responsibility for payments not covered by your Motor Vehicle Insurance or WSIB
- Supervise young children to prevent injury
- Let us know if you are uncomfortable having parts of your treatment provided by physiotherapy assistant students or physiotherapy students
- Help our practice grow

Welcome to Active Physiotherapy Solutions!

Patient Signature ____________________ Date_______________