Essential
Physiotherapy
& Wellness

## Essential Physiotherapy – Contact Information

Name: ______________________________ Occupation: ______________________

Address: ________________________ City: ______________ Postal Code: __________

Phone: (1st Preference) ________________ (2nd) ______________ (3rd) ______________

Family Doctor: ________________ Doctor Phone/Address: ________________________

Date of Birth (dd/mmm/yyyy): ________________ How did you hear about us? ________________

**IS YOUR VISIT THE RESULT OF A CAR ACCIDENT OR WORKPLACE INJURY?** ☐ Yes ☐ No

Email Address: ____________________________________________________

By signing below you understand that Essential Physio is compliant with Anti-Spam Legislation. All email contact with you will be for the purposes of your health care such as newsletters, appointments and follow-up. ________________________

## Medical Information Release

I, ________________________, hereby give permission to Essential Physiotherapy to contact and share or receive health information with my family physician, or any other health professional to determine my progress.

Signature: ________________________ Date: ________________________

Companies We Direct Bill (we will require a photocopy of your card):

☐ Greenshield ☐ Sun Life ☐ OTIP

☐ Blue Cross ☐ Great West Life ☐ Manulife

Policy # ______________ Member ID # ______________ Employer Name ________________

(Complete if you are not the Benefit holder)

Name of Policy Holder ____________________ Relationship ____________________

Birthdate of Policy Holder ________________

☐ I have benefits from a different company – Who? ________________ ☐ I do not have Benefits

# HEALTH CONSENT FORM (Physiotherapy)

*We need your informed consent. This means that we need you to understand the services we provide, the costs, and what we do with the personal information we gather about you. Please ask us if you have any questions.*

## CONSENT FOR THE COLLECTION OF PERSONAL INFORMATION

I understand that to provide me with physiotherapy or massage therapy and services, Essential Physiotherapy (herein known as the company) will collect some personal information about me. (e.g., name, address, phone numbers, and health history).

I have had the opportunity to review The Company's Privacy Policy about the collection, use, and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the privacy policy applies to me. I have been given a chance to ask questions I have about the privacy policies and they have been answered to my satisfaction.

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.

I agree to The Company collecting, using, and disclosing personal information about me as set out above and in The Company's Privacy Policy.

## FEE SCHEDULE

Physiotherapy treatments in our clinic are NOT COVERED BY OHIP. Extended Health Insurance coverage for physiotherapy is provided by various companies and we advise you to determine if you have such coverage (we will be happy to provide you with invoices so you can submit to your insurance company). If you are seeking physiotherapy treatment as a result of a W.S.I.B. claim, or Motor Vehicle Accident, please advise us of such and we will initiate the appropriate billing.

However, please be advised that our contract is with you, the patient, and therefore you are ultimately responsible for payment of treatments rendered. This applies to all coverage methods (ie. Extended Health Care, W.S.I.B, and Motor Vehicle Insurance etc…). Please feel free to direct your questions to our staff. We will make every effort to assist you with your claim.

We accept Visa, MasterCard, American Express, Interac, Cheque or Cash.

| | Orthopedic | Pelvic | Vestibular ** |
|---|---|---|---|
| Initial Assessment | $90/$100 | $115 | $100 |
| Subsequent Treatments | $70/$100/$135 | $105 | $75 |
| Missed/ No Show Appointments | Full fee | Full fee | Full fee |
| Short Notice Cancels | 50% of fee | 50% of fee | 50% of fee |
| Cancelled Appointments (with 24 Hours Notice) | No charge | No charge | No charge |

*Subsequent treatment fees are based on therapist recommendations appropriate for the problems identified and will be clearly outlined prior to treatment
** Vestibular refers to patients with dizziness, vertigo, and imbalance.

**See other side**

**INFORMED CONSENT TO PHYSIOTHERAPY TREATMENT AND CARE**

In April, 1995, the Ontario Government passed the Consent to Treatment Act to safeguard the rights of people to make their own informed decisions about health treatment. The legislation requires that our therapists provide you with the necessary information on the treatment proposed so that you can make an informed choice. The purpose of this document is to outline what is involved in our physiotherapy treatment.

Depending on your needs, your program may consist of any of all of the following:

- Therapeutic exercise to restore strength and range of motion
- Electrical modalities to decrease pain and inflammation, and to promote healing
- Hands-on manual techniques to restore functional mobility and reduce pain
- Progressive strengthening and aerobic exercise to restore and maintain normal muscle strength and endurance.

Your treatment program will be designed and monitored by your physiotherapist. A Kinesiologist and/or Physiotherapist Assistant may also provide assistance in your daily care.

As in all health care, in the practice of physiotherapy, there are some risks associated with treatment, although rare. They include, but are not limited to muscle strains and sprains, fractured bones, and burns from electrical modalities.

The program is tailored to your specific stage of recovery. You may find that you are a little more stiff and sore after an initial assessment. This is because the physiotherapist must put your body through some movements that you may not normally do in order to determine the nature of the problem. Please keep the physiotherapist informed about changes in your symptoms during the course of treatment so that they can respond accordingly. We ask that you follow the therapist's instructions so that you perform the activities in a safe manner to avoid any risk of injury.

You may discontinue the treatment at any time, but we ask that you extend the courtesy of informing one of our staff of your intention to discontinue and your reasons for doing so.

If you have any further questions, you are encouraged to ask our therapists.

I have been informed of the treatment outlined above and its possible risks. I voluntarily give consent to participate in the rehabilitation program and realize that I may, at my discretion, discontinue treatment at any time. **I also understand that 24 hours notice of cancellation is expected in order to avoid billing my personal account.** By signing below, I intend this consent form to cover the entire course of treatment for my present condition.

______________________________ ______________________________

Signature Date

______________________________

Printed Name

**Notes:**

E&OE

Essential Physiotherapy & Wellness | BIRTH ESSENTIALS

Name: ______________________________

Birthdate: ___________________________

## Symptom Monitor and Pain Questionnaire

We take a whole-person approach to your symptoms. We recognize that pain, bladder/bowel symptoms, muscle spasm and other symptoms have both a physical and emotional component to them. To get to the root of your problem(s), we will be asking you many questions that will help us to fully assess your Problem and the impact that it is having on your life. If any of these questions don't apply to you or your symptoms just leave them blank. Thank you for taking the time to share your story with us!

Presenting Problems ________________________________________________________________________

________________________________________________________________________________________

When did it start? __________________________________________________________________________

### Medical History/Screen

Are you currently pregnant? □ Yes □ No If yes, how many weeks _______________

Recent infections? ________________ Explain? ____________________________________________________

Urinary tract infections □ Yes □ No How Often? ____________________ Last UTI? ________________

Yeast infections □ Yes □ No How often? ______________ Last infection ___________Treatment _____________

Do you get blood in your urine? □ Yes □ No

Smoking □ Yes □ No # ___ packs/day Chronic cough □ Yes □ No

Allergies (including latex): _____________________________________________________________________

Do you have any food allergies or sensitivities? ____________________________________________________

Do you exercise? □ No □ Yes Type: ___________________________Frequency:_________________________

Low back problems? □ Yes □ No Mid back problems? □ Yes □ No Neck problems? □ Yes □ No

Have you been treated for depression? □ Yes □ No Have you been treated for anxiety? □ Yes □ No

Have you ever been diagnosed with a mental health condition? □ No □ Yes If yes, what? __________________

**Please check off any of the following medical conditions that you currently have or have had in the past:**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| □ | Skin conditions | □ | Overactive bladder | □ | Pacemaker | □ | High blood pressure |
| □ | Heart disease | □ | Rectal bleeding | □ | Paralysis | □ | Arthritis |
| □ | Vision changes | □ | Chronic fatigue | □ | Osteoporosis | □ | Numbness |
| □ | Speech difficulties | □ | Cancer or malignancy | □ | Dizziness | □ | Sjogren' s disease |
| □ | Joint replacements | □ | Breathing difficulties | □ | Diabetes | □ | Blood in the urine or stool |
| □ | Thyroid problems | □ | Endometriosis | □ | PCOS | □ | Inability to void bladder/bowel |
| □ | Multiple sclerosis | □ | Recent weight loss | □ | Stroke | □ | Severe abdominal pain |
| □ | Ulcerative colitis | □ | Neck injury/whiplash | □ | Depression | □ | Irritable bowel syndrome |
| □ | Crohn's Disease | □ | Anxiety/panic attacks | □ | Fibromyalgia | □ | Restless leg Syndrome |
| □ | TMJ Disorder | □ | Lupus | □ | Celiac Disease | □ | Multiple chemical sensitivities |
| □ | Night pain | □ | Unusual vaginal bleeding/discharge | | | | |

Please list any additional medical issues, illness or diagnosis you are currently undergoing treatment or investigation for, or are relevant to your condition: ______________________________________________

________________________________________________________________________________________

**Gynecological History - please complete the following section if this applies to you**

What age did your period start? ______ Is your cycle regular?□ Yes □ No Is bleeding heavy? □ Yes □ No

Do you have pain with your period? □ Yes □ No

Do you use tampons? □ Yes □ No Do you have pain with insertion of a tampon? □ Yes □ No

Sexually active? □ Yes □ No Pain with intercourse? □ Yes □ No

Do you use lubrication? □ Yes □ No □ Sometimes What type: ____________________

Birth control? □ Yes □ No Type: _________________

# of pregnancies __________ # of live births ______ Wt. Heaviest baby ___ lbs ___ oz

Age of child(ren) ____________________length pushing stage ______ hours

# of vaginal deliveries ______ # of C-sections _______ Forceps? □ Yes □ No Vacuum? □ Yes □ No

Did you have an epidural? □ Yes □ No Episiotomies? □ Yes □ No Tears? □ Yes □ No Grade of tear ______

Have you gone through menopause? □ Yes □ No If so, when? __________________

Have you ever been told you have a prolapse? □ Yes □ No

Do you physically feel something coming out of your vagina (with your hand)? □ Yes □ No

Do you have feelings of heaviness/pressure in your vagina? □ Yes □ No

Do you have incomplete emptying when you void and feel like you have to go again soon? □ Yes □ No

Does your incontinence fluctuate with your cycle? □ Yes □ No □ Sometimes

Does your incontinence require you to wear pads? □ Yes □ No □ Sometimes how often? _____

Do you void during the day more than the average person (5-7x/day)? □ Yes □ No How Often? ____

Do you need to get up at night to void? □ Yes □ No How many times? _________

In your opinion, is your fiber intake □ Too Low □ Adequate □ Too High

Do you regularly use □Laxatives □ Stool Softeners □ Natural Products □ Enemas

**Have you had any of the following medical procedures? If so, please provide the approximate date:**

| | | |
|---|---|---|
| Appendectomy _______________ | Bartholin Cyst _________________ | Bowel resection _______________ |
| Laparoscopy __________________ | Cystoscopy____________________ | Colonoscopy __________________ |
| TVT-TVT(O) ___________________ | Gallbladder removal ___________ | Hemorrhoid surgery ____________ |
| Mesh procedure _______________ | Prolapse/Vaginal repair ________ | Hysterectomy _________________ |
| Colostomy ____________________ | Urodyanmics __________________ | Other ________________________ |
| Hernia repair __________________ | Tubal ligation _________________ | ______________________________ |

Any other Health information you feel we should know _______________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Essential Physiotherapy & Wellness

**DASS QUESTIONNAIRE**

Name: ___________________________

Date: ___________________________

Please read each statement and circle a number, 0, 1, 2 or 3, which indicates how much the statement applied to *over the past week.* There are no right or wrong answers. Do not spend much time on any statement.

**0 …... Did not apply to me at all**
**1 …... Applied to me to some degree or some of the time**
**2 …... Applied to me a considerable degree, or a good part or a good part of the time**
**3 …... Applied to me very much, or most of the time**

| | |
|---|---|
| S | I found it hard to wind down |
| A | I was aware of dryness of my mouth |
| D | I could not seem to experience any feeling at all |
| A | I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion |
| D | I found to difficult to work up the initiative to do things |
| S | I tended to over-react to situations |
| A | I experienced trembling (e.g. in the hands) |
| S | I felt that I was using a lot of nervous energy |
| A | I was worried about situations in which I might panic and make a fool of myself |
| D | I felt that I had nothing to look forward to |
| S | I found myself getting agitated |
| S | I found it difficult to relax |
| D | I felt downhearted and blue |
| S | I was intolerant of anything that kept me from getting on with what I was doing |
| A | I felt I was close to panic |
| D | I was unable to become enthusiastic about anything |
| D | I felt that I was not worth much as a person |
| S | I felt that I was rather touchy |
| A | I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat) |
| A | I felt scared without any good reason |
| D | I felt that life was meaningless |

S = _______ D = ______ A = ______

Essential Physiotherapy & Wellness

Name ____________________

**PCS QUESTIONNAIRE**

Everyone experiences painful situations at some point in their lives. Such experiences may include headaches, tooth pain, joint or muscle pain. People are often exposed to situations that may cause pain such as illness, injury, dental procedures or surgery.

We are interested in the types of thoughts and feelings that you have when you are in pain. Using the following scale, please indicate the degree to which you have these thoughts and feelings when you experience pain.

**0 …... Not at all**
**1 …... To a slight degree**
**2 …... To a moderate degree**
**3 …... To a great degree**
**4 …… All the time**

**When I'm in pain ….**

| I worry all the time about whether the pain will end |
|---|
| I feel I can't go on |
| It's terrible and I think it's never going to get any better |
| It's awful and I feel that it overwhelms me |
| I feel I can't stand it anymore |
| I become afraid that the pain will get worse |
| I keep thinking of other painful events |
| I anxiously want the pain to go away |
| I can't seem to keep it out of my mind |
| I keep thinking about how much it hurts |
| I keep thinking about how badly I want the pain to stop |
| There's nothing I can do to reduce the intensity of my pain |
| I wonder whether something serious will happen |

Total: ______/52 = ______%

**Electronic Transmission Authorization and Consent Form**

**(Complete if you have Benefits We Direct bill)** *Instructions: This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.*

**Provider**:

Essential Physiotherapy & Birth Essentials
97 Brant Ave, Brantford
N3T 3H4
(519) 752 2151

**Patient**: ______________________________________

Address: ______________________________________

City/Province: ________________________________

Postal Code: __________________________________

Phone Number: _________________________________

Plan Number: __________________________________

Certificate / Plan member Number: ________________________

## Consent to Collect and Exchange Personal Information

**Message to the Plan member, Spouse and/or Dependent regarding Personal Information**
Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

**Authorization and Consent**
I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.
I authorize the insurer and / or plan administrator and their service provider(s) to:
use my personal information for the above purposes.

Exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.

Exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member. Exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

*I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.*

### Additional Consent Applicable to Plan Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

| Date: | Signature | Print |
|---|---|---|

## Benefit Assignment

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

| Date: | Signature | Print |
|---|---|---|