**PATIENT INTAKE FORM**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_ Date of Birth (day/month/year) \_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Province: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian (for under 18): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Can we contact your family physician: Y/N

Who can we thank for your referral?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your chief complaint/reason for visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Date of injury (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Or gradual onset
* Chronic issue

Have you seen a physician regarding the above issue? YES/NO

Do you have any test results or imaging results related to your reason for visit? YES/NO

Are you currently seeing any otherhealthcare professionals?

Chiropractor Massage Therapist Naturopath Traditional Chinese Medicine Practitioner

Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_\_\_\_\_

Have you seen a Physiotherapist before? YES/NO

**MEDICAL HISTORY QUESTIONNAIRE**

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The following information is required to provide you with the best possible care. All information is strictly private and is protected by patient confidentiality.**

1. Are you taking any medication, non-prescription drugs or herbal supplements of any kind? YES/NO. If YES, please list.
2. Have you ever been hospitalized for any illnesses, surgeries, or operations? YES/NO. If YES, please list/explain.
3. Do you have any allergies to medications or latex/rubber products? YES/NO. If YES, please list.
4. Have you had a history of broken bones, ligament tears/sprains, and did you have surgery for this? YES/NO. If YES, please provide details.
5. Have you ever had any HEART problems? Please check off.

|  |  |  |
| --- | --- | --- |
| \_\_Chest pain/angina | \_\_Heart valve problems | \_\_Heart attack |
| \_\_Congestive heart failure | \_\_High blood pressure | \_\_Pacemaker |
| \_\_Irregular heart beat | \_\_Heart disease/blocked arteries | \_\_Palpitations |
| \_\_Cardiac Surgery | \_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

1. Do you currently have, or have you ever had, any of the following? Please check off.

|  |  |  |
| --- | --- | --- |
| \_\_Diabetes | \_\_Stroke | \_\_Circulatory problems (e.g. leg swelling, blood clots) |
| \_\_Cancer | \_\_Chemo/radiation | \_\_Osteoporosis/weak bones |
| \_\_Asthma | \_\_Respiratory/lung conditions | \_\_Seizures/convulsions |
| \_\_HIV/AIDS | \_\_Tuberculosis | \_\_Hepatitis |
| \_\_Bleeding/blood disorder | \_\_Vestibular/dizziness problems | \_\_Recurring headaches/migraines |
| \_\_History of falls/falling | \_\_Concussion/head injury | \_\_Motor vehicle accident |
| \_\_Osteoarthritis | \_\_Rheumatoid arthritis | \_\_Prosthetic/artificial joint |
|  |  |  |
| \_\_Liver/kidney disease | \_\_Thyroid disease | \_\_Autoimmune conditions |
| \_\_Hormonal imbalance | \_\_Gynecological conditions | \_\_Anxiety/depression |
|  |  |  |
| \_\_Recent weight gain/loss | \_\_Incontinence | \_\_Multiple sclerosis (MS) |
| \_\_Chronic pain | \_\_Fibromyalgia |  |
|  | | |
| \_\_Others (please list):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

1. For women only: Are you pregnant or is there a chance you could be pregnant? YES/NO

If YES, what is the expected delivery date?

1. Is there anything else about your health we should be aware of? Please provide details.

**To the best of my knowledge, the provided information is correct.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Signature Date

**Consent for ASSESSMENT/Treatment – Physiotherapy**

The purpose of physiotherapy is to treat disease, injury and disability by examination, evaluation, diagnosis, and intervention. Physiotherapy treatment techniques may include, but are not limited to, manual techniques including mobilization/manipulation, acupuncture, electrotherapeutic modalities, and exercise. A number of these may be recommended during your treatment program. All benefits, side effects, and potential complications of each chosen modality will be explained to you by your therapist before use.

In many cases, the area of injury will need to be exposed in order to effectively provide treatment and you may be asked to disrobe. If this is necessary, your privacy, modesty, and dignity will be considered at all times. Should you feel uncomfortable or embarrassed at any time, you may refuse or ask to stop the treatment.

Throughout your treatment plan, if you have any questions or concerns about any recommended treatment, you must inform your therapist immediately so she can explain the treatment rationale and/or modify your treatment appropriately. If at any time you chose not to participate in any portion of the treatment program, you must inform your therapist immediately. You will inform your therapist of any injuries, change in medical condition, new symptoms or change in demographic information as soon as they occur.

I understand and agree with the criteria above and as such agree to participate in assessment and treatment by a Physiotherapist at Stouffville Healthworks. I understand that for the duration of my treatment, my consent may be withdrawn at any time and I understand that I must inform my Physiotherapist.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_

Guardian Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**What is Acupuncture?**

Acupuncture is a therapeutic method used to encourage natural healing, reduce or relieve pain, and improve function of affected areas of the body. It involves the insertion of very fine needles through the skin and tissue at specific parts of the body.

People experience different sensations with acupuncture. Most feel only minimal discomfort when the needle is inserted. Once the needles are in place, there should be no significant discomfort. Some people report an “achy” or “heavy” sensation around the area of the needle, which is a completely normal response and should not be uncomfortable. A typical treatment time is 15-20 minutes.

**CONSENT FOR ACUPUNCTURE AS A PHYSIOTHERAPY TREATMENT TOOL**

Only pre-sterilized, single use needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

I understand and am informed that in the practice of acupuncture, there are some risks to treatment, including, but not limited to: minor bleeding or bruising, minor pain or soreness, nausea, fainting, fatigue,infection, possible perforation of internal organs (may not be an applicable risk, depending on site of needle insertion), and stuck or bent needles.

I wish to rely on the therapist to exercise judgement during the course of the treatment, which the therapist feels at the time, based upon the facts then known, is in my best interest.

The therapist will ensure the above risks are minimized (including choosing low risk points), however I do not expect the therapist to be able to anticipate all possible risks and complications.

I understand that results are not guaranteed.

*For FEMALE patients who are PREGNANT:*

*I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment is possible. I hereby state that I am not pregnant, nor is there any possibility I may be pregnant.*

I have read the above consent form and understand the explanation. By signing below, I accept that I understand the associated risks and benefits, and consent to the use of acupuncture as a treatment tool by my Physiotherapist.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

**Benefit plan policy**

Benefit plans are designed to keep your out of pocket expenses to a minimum. As a courtesy to you, we will bill your health insurance for payment. If you have a co-pay, these will be collected at time of service. We ask that you leave a credit card to guarantee payment of any additional fees (non-payment due to auditing, unexpected co-pay, etc), and by doing so you authorize Stouffville Healthworks to collect unpaid office visit charges . **If you would like us to provide you with this service we do require your credit card information.**

If we need to charge your card, you will be called before we do so. Please note that your credit card number will be stored electronically in a password protected file.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date Credit Card Number & Expiry

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Benefit Plan Name Benefit Plan Group Policy # Benefit Plan Member #

\*If you are not the primary benefit member, please include the member's name and date of birth

\*If this appointment is for a child, please include the primary benefit member's name and DOB.

**Missed appointment and cancellation policy**

There is a $30 fee for missed appointments, and for appointments cancelled without 24 hours notice from January to September and 48 hours notice from October to December.

The $30 fee cannot be charged to your insurance plan.

Special consideration will be made for emergency situations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Witness Signature