ASSESSMENT INTAKE FORM

PATIENT INFORMATION:

Patient Name: _____

Date Of Birth: _____(DD/MM/YYYY)

Address: _____

Home Number: _____ Cell Number: _____

Email_____

Appointment Reminders by: Email_____ Phone_____ None_____

Do you have private insurance? YES / NO

Who with: _____

Workplace Injury: YES / NO Car Accident: YES / NO

Claim number: _____

Claim Number and/or Policy Number: _____

Family Dr.: _____ Referring Dr.: _____

Main problem: _____

MEDICAL INFORMATION: (Please check all that apply)

___Diabetes	___Cancer	___Nervous System Disorders
___High Blood Pressure	___Allergies	___Pregnant
___Heart Attack	___Operations	___Dizziness
___Pacemaker	___Seizures	___Hepatitis/HIV/AIDS
___Frequent Headaches	___Metal Implants	___Smoker

Other:_____

Medication List:_____

_____

I understand that I will be charged a fee of $75 for any appointment missed without at least 24 hours' notice for cancellations or rescheduling, to be provided within standard business days (Monday-Friday)

I am responsible for my physiotherapy treatment payments at each visit.

Consent to Collect / Disclose Personal and Personal Health Information

I hereby give ActiveCare Physiotherapy-Barrhaven permission to receive and disclose information pertaining to my condition and treatment with the appropriate medical personnel. This consent will be considered valid for one (1) year from the date signed. Photocopies and faxes will be considered valid if required as proof of consent prior to communication occurring. Please be advised that ActiveCARE Physiotherapy-Barrhaven is the health information custodian of your clinic file.

Consent to Assessment and Treatment

I consent to partake in the physiotherapy assessment/treatment including a) review of my medical history and current injury, and b) physical examination which may include palpation of the painful area and both active and passive movement testing. I understand that upon completion of the assessment the physiotherapist will provide me with his/her opinion and provide me with information regarding my treatment options.

Signature _____ Date _____

Be aware the clinic sells medical supplies including, but not limited to custom orthotics, TENS units, custom bracing, braces, splints, and pillows. You are free to use any other supplier of these products. Please ask your physiotherapist if you would like to use an external supplier.

Please be advised that your referring physician may have proprietary interest in ActiveCARE Physio – Barrhaven. You have the option of choosing any provider.