ActiveCARE Physio
OTTAWA

ASSESSMENT INTAKE FORM

PATIENT INFORMATION:

Patient Name:_____ Date Of Birth:_____

Address:_____ Gender : _____

Home Number:_____ Cell Number:_____

Email_____ Emergency Contact: _____

Appointment Reminders: Email_____ Phone_____ None_____

Private Insurance: ___YES ___NO Name of Private Insurance: _____

Policy Number: _____ID/Certificate Number:_____

Work Place Injury: ___YES ___NO Car Accident: ___YES ___NO

Referred by: Dr._____ Family Doctor:_____

MEDICAL INFORMATION:

___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 Lists:_____

PLEASE FILL ONLY IF HERE FOR A KNEE OR FOOT PROBLEMS:

___ Are your feet sore on a regular basis? ___ Do you have heel pain on a regular basis?

___ Do you have visible foot problems (bunions, fallen arches, callouses, corns?

___ Do you experience tired or aching legs? ___ Do you experience swollen feet, ankles, or legs?

___ Do you sit or stand for long periods of time during the day?

___ Do you have a family history of venous leg disorder?

___ Are you immobile most of the day?

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-Orleans 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-Orleans 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

_____

Please Print Name

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 Dr.(s) Aeta, Aubin have a proprietary interest in ActiveCARE Physiotherapy-Orleans. You have the ability to choose any provider.