Heritage Park Physical Therapy

Please Print Clearly ***Please Complete All Information***

Who can we thank for your referral? (internet, friend, family) _____

Name: _____ Birthdate: (mm/dd/yyyy): _____ Gender: M/ F

Address: _____ City: _____ Postal Code: _____

Home Phone:_____ Cell: _____ Work: _____

Email Address: _____
Do we have your permission to send you emails (for appointment reminders, newsletters etc? (Yes / No)

Occupation: _____ Company: _____

Do you have extended healthcare? Yes/ No If yes, who with?: _____

Have you had previous physiotherapist care? Yes / No When was your last visit? _____

Who is your Medical Doctor? _____

Who is your Massage Therapist? _____ Other Healthcare Practitioner? _____

Welcome to Heritage Park Physical Therapy! We want you to understand and consent to the services we provide to you, the costs involved, and what we do with personal inforamtion we obtain about you. If you have questions about any of this, please ask.

Our expectations of patients for services rendered by Heritage Park Physical Therapy:

- We expect all patients to pay for all services when they are provided. If you do not pay for a service at the time it is received, an interest rate of 3% per month will be applied to all outstanding balances and, on default, to pay all costs of recovering debt, including and/ or agent costs.
- We expect all patients to provide **24 hours notice when cancelling an appointment**. Your appointment time is reserved exclusively for you and our professionals cannot use this time to see other patients if you do not provide 24 hours notice or cancellation; you agree to pay our standard fee for the missed appointment, as if you had attended.
- The fee schedule is:
    - New Patient Examinations if $90.00
    - Physiotherapy Treatment $65.00
    - Re- assessments (greater than 3 months) are $75.00.
- From time to time your Insurance Company may audit you for dates and treatments, signing below gives Heritage Park Physical Therapy permission to release Account Statement information to the company upon their request.

_____ Date: _____ 20_____

Signature or Patient (or legal guardian)

Past Medical History

Any major surgeries or hospitalizations:_____

Lifestyle Factors

Do you smoke? Yes/ No How many packs per day? _____ for _____ years

What do you do for fun? _____ To stay active? _____

Please check any symptoms that you have had in the past or are presently experiencing.
Mark the boxes: C= Current P= Past

MUSCULOSKELETAL	***GENERAL***	***CARDIOVASCULAR***
Low Back Pain	Allergies	Chest Pain
Mid Back Pain	Loss of Sleep	Short of Breath
Neck Pain	Fever	High Blood Pressure
Arm Pain	Headaches	Irregular Heartbeat
Join Pain/ Stiffness	Night Pain	Lung Problems
Problems Walking	Decreased Appetite	Varicose Veins
NERVOUS SYSTEM	Excessive Thirst	Ankle Swelling
Numbness	Frequent Nausea/ Vomiting	Calf Pain
Paralysis	***MALE/ FEMALE***	Stroke/ Heart Pain
Dizziness	Irregular Menstruation	
Forgetfulness	Menstrual Cramps	***GASTROINTESTINAL***
Confusion/ Depression	Vagina Pain/ Infections	Liver Problems
Fainting	Breast Pain/ Lumps	Abdominal Cramps
Convulsions/ Seizures	Prostate Problems	Weight Loss
Tingling	Other	Gas/ Bloating
Loss of Sensation	**EENT**	Heartburn
Stress = Rate your stress level on a scale of 1- 10 (10= highest)	Vision Problems	Black/ Bloody Stool
	Sinus Problems	Colitis
	Ear Aches	Crohn's Disease
	Difficulty Hearing	

Any other medical conditions not listed:

_____

_____

_____ Date: _____ 20_____

Signature or Patient (or legal guardian)

People seek the care of a Physiotherapist for many reasons; please check the one that applies to you so we can serve you better.

_____ I have a specific problem and only require help with this problem

_____ After my problem, has been relived I want to ensure the problem does not return

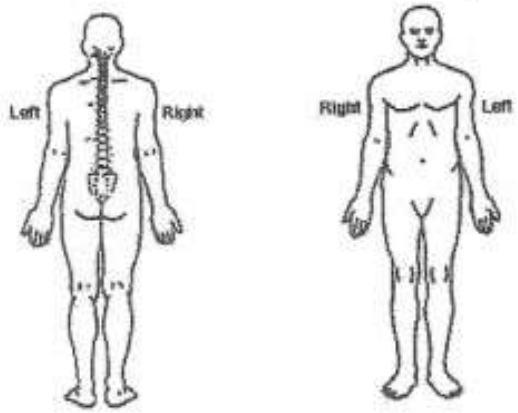
_____ Spinal check-up and to improve my general health

Reason for appointment/current complaint: _____

Is this condition: Auto Related / WSIB Claim / Sport Injury / Gradual Onset / Other: _____

Please circle the following diagram based on location of pain or discomfort.

Dull Ache	(A)
Sharp	(H)
Tingling	(T)
Numbness	(N)
Burning	(B)
Stiffness	(F)
Tight	(G)
Other	(X)



Please place an x on the grade indicating the severity of your pain.

(Least) 1 2 3 4 5 6 7 8 9 10 *(Worst)*

Is your complaint: Constant / Intermitted / Re- Occurring

Have you seen someone else for this condition? _____

Type of Treatment: Results: _____

Current Medications: Pain Killers / Muscle Relaxants / Blood Pressure / Insulin / Anticoagulants

Please List: _____

Any other questions, comments or concerns? _____

_____ Date: _____ 20_____

Signature or Patient (or legal guardian)