Physiotherapy Patient Information

Name:_____ Date of Birth (DD/MM/YYYY): _____
Address: _____
Home phone:_____ Work: _____ Cell:_____
Email address: _____
Occupation:_____ Family physician:_____ Phone number: _____
NS Health Card (MSI number):_____
Concurrent treatments: [ ] chiropractic [ ] massage [ ] naturopathy [ ] dietetics

Whom may we thank for referring you to our clinic? [ ] Name: _____
[ ] Newspaper Ad [ ] Yellow Pages Listing [ ] Other: _____

Do you have a health history of any of the following? Please check all that apply.

[ ] Diabetes	[ ] High blood pressure	[ ] Asthma
[ ] Cardiac disease	[ ] Blood clots	[ ] Stroke
[ ] Liver or kidney disease	[ ] Lung disease	[ ] Thyroid disease
[ ] Cancer	[ ] Multiple sclerosis	[ ] Migraines
[ ] Anxiety and/or depression	[ ] Osteoporosis	[ ] Arthritis
[ ] Smoker _____ ppd	[ ] Metallic implants (pins, etc.)	[ ] Currently pregnant

[ ] Other: _____

Have you also recently experienced:
[ ] double vision or dizziness [ ] difficulty with speech/swallowing [ ] ringing in the ears
[ ] changes in bowel/bladder function [ ] frequent headaches [ ] changes in appetite or weight

Current medications (include aspirin, vitamins, minerals, prescription and non-prescription):
_____
Allergies: _____
Please list previous surgeries and severe injuries: _____
_____
Physical activities (frequency and type):_____
_____

Current complaint:_____
Type: [ ] Acute injury [ ] Chronic complaint [ ] Post-op [ ] Pre-op [ ] MVA [ ] WCB
Adjuster/Caseworker Name_____ Claim #_____
Contact Information _____
How did it happen?_____
Date symptoms started:_____ Date visited physician? _____
Treatment received? _____
Have you had diagnostic imaging? [ ] X-ray [ ] CT scan [ ] MRI [ ] None
Date and results (if applicable): _____

On a scale of 0 (least) to 10 (most severe), what is your pain:

Now?	0	1	2	3	4	5	6	7	8	9	10
Worst?	0	1	2	3	4	5	6	7	8	9	10
Best?	0	1	2	3	4	5	6	7	8	9	10

What makes your pain worse?_____ _____
What makes your pain better? _____
Your pain is (circle all that apply): aching burning numbness tingling sharp dull radiating
Does your pain wake you up at night? [ ] yes [ ] no
Does your current condition interfere with [ ] daily tasks [ ] exercise routine [ ] work
What are your goals for physiotherapy? _____

Physiotherapy Consent Form

PLEASE READ CAREFULLY AND THROUGHLY, AND INTIAL EACH SECTION

I. Informed Consent

- I understand that I need to express all of my health concerns (both current and past) to my therapist, including any contagious or infectious condition that I might have.
- I consent to an examination and treatment performed by a licensed physiotherapist. The results will the assist the physiotherapist in determining the appropriate physical treatment to meet my specific needs and goals.
- I understand that my treatment with the physiotherapist may involve the use of physical and electrical modalities, acupuncture, stretching or mobilization of joints and tissues, and exercise programs aimed at mobility, strength and function
- I understand that discomfort may occur following treatment. The therapist will contact my physician should the presence of symptoms represent any potential risks. I understand that it is my responsibility to contact my therapist should I experience any unusual symptoms.
- I understand that aspects of my treatment may be carried out by assistants or students under the supervision of the physiotherapist.
- I understand that if at any time I am not comfortable with, and/or do not understand the purpose of any treatment procedure I will ask the physiotherapist for further explanation/information. I understand that I may stop the assessment or treatment procedure at any time.

I have read, understood, and had the opportunity to discuss the Informed Consent form.

Initial: _____

II. Privacy Policy

We collect, use, and disclose health information according to the Personal Health Information Privacy Act.
I agree to Kinesis Health Associates collecting, using and disclosing my health information to:

- other health practitioners of Kinesis and/or Alderney Chiropractic _____
- my family physician or referring doctor _____
- my insurer, as required _____

III. Billing Policy

FEES AND PAYMENTS	ADULT FEE	STUDENT FEE
• Initial physio. assessment	$80	$70
• Follow-up physio. treatment	$70	$65
• Follow-up laser treatment	$45	$40
• No-show charge	50% of visit fee	50% of visit fee

READ AND INITIAL THE FOLLOWING

- I understand the fee schedule as outlined above. _____
- Payment or co-payment is required at time of service. _____
- If your claim is denied, you are responsible for payment. _____
- If you do not provide more than 24 hours notice to cancel or reschedule an appointment, a $20 no-show fee may be added to your account. _____

If you have private health insurance, please fill out the following information:

Physiotherapy Coverage Percent _____ %
Physiotherapy Maximum Benefit $_____/ year

IV. Signature

My signature below indicates my understanding of all of the above information.

_____ _____ _____
Signature of patient (or guardian) Witness Date