Physiotherapy Medical History Form

Name (first/last)_____ Birthdate (D/M/Y):_____

Address:_____ City:_____ Postal code:_____

Home:_____ Work :_____ Cell:_____

Email address:_____

Emergency contact: _____ Phone_____

Referring physician:_____ Family physician:_____

How did you hear about our clinic? _____

Please list any previous accidents or injuries._____

_____

Please list all current medications:_____

_____

Private health insurance varies please check with yours to ensure you know what is covered.

Insurance company: _____ Policy number:_____ ID number:_____

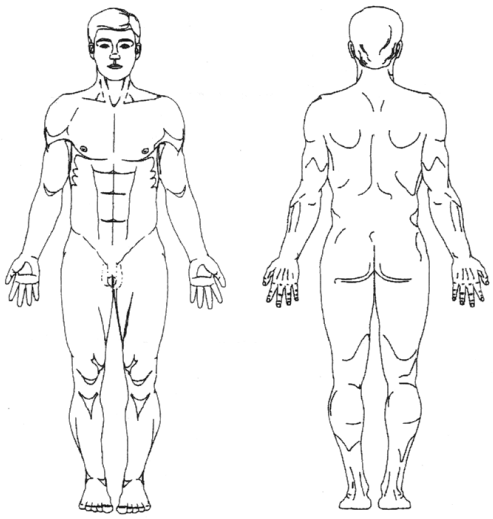
Please check off any of the following issues that you may have.

o Skin conditions	o Pregnancy	o Breathing difficulties	o High blood pressure
o Heart disease	o Pacemaker	o Deep brain stimulator	o Arthritis
o Osteoporosis	o Chronic fatigue syndrome	o Bowel/bladder problems	o Fibromyalgia
o Diabetes	o Stroke	o Caner or malignancy	o Numbness
o Joint replacements	o Rapid weight loss		

_____

Are your injuries related to a car accident?_____ Date of accident_____
If yes please complete car accident forms

Are you injuries work related?_____ Health Card number_____
If yes please complete WCB forms



Injury

Area injured_____

How injury happened? _____

Date injured_____

Things that make the pain better?_____

Things that make the pain worse?_____

Things I can't do due to injury _____

Other information about injury

_____

Patient Consent to Release of Information

All patient information is considered confidential and used solely for the purpose of providing care and management of your account. Spryfield Physiotherapy may have to contact some or all of the following people to allow successful injury recovery and payment of account.

- Physician, specialist, insurance company
- WCB and employer (for WCB claims only)
- Insurance adjuster and/or lawyer (for car accident claims only)

I agree to let Spryfield Physiotherapy communicate as needed with individuals indicated above regarding my care and payment of the account.

Client signature _____ date _____

Witness signature _____ date _____

Payment and Cancellation Policy

- Payment is to be collected at the end of each treatment.
- We do direct bill certain insurance companies. It is your responsibility to keep track of the treatments attended so you do not to exceed your coverage. Please check with your insurance provider. Any payment not covered by the insurance company will be your responsibility.
- For car accident claims, if your insurer refuses to pay you will be responsible for the cost of the treatment so ensure **section B insurance forms** are completed and returned to the insurance company. Car accident claims must be put through the private insurance first (this is N.S. law)
- If WCB claim is disallowed you will be responsible for the cost of treatment.
- **If you miss or cancel an appointment with less than 24 hours notice you will be charged 50% the cost of the treatment.** Health plans, insurers, and WCB do not pay for missed appointments so you will have to pay the cost personally.

Client signature _____ date _____

Witness signature _____ date _____

Consent to treatment (to be signed after interview with therapist)

Physiotherapy includes hands on treatment, modalities (ice, heat, ultrasound, muscle stimulation etc.) as well as exercises to assist in your recovery. Aims of physiotherapy are reduce swelling, reduce pain, increase strength, and improve function. All information will be considered confidential and treated as such. Your physiotherapist will work within their scope of practice to the best of their abilities to offer effective treatment. The initial assessment and some treatments may temporarily increase pain. This will be discussed with you by your therapist. Results can't be guaranteed and the therapist will not accept liability for the results of the treatment.

I _____ understand that physiotherapy in being provided for the purpose of assisting with healing and/or function. My medical history is true and I will tell my therapist if any part of the medical history changes during the course of my treatment. I have been informed by of the benefits, risks, and potential side effects of treatment along with possible alternatives. I have the right to stop or change treatment at any time. I have read and understand this form and give my consent to begin treatment.

Client signature _____ date _____

Therapist signature _____ date _____