Active Chiropractic Family Health Centre

Physiotherapy Health History Form

Office Use Only			
☐ MB		☐ Ref.	
☐ Rel.		☐ FV	
☐ IFS		☐ Wel.	
☐ Update			

For Your Information:

An accurate health history is important to ensure that it is safe for you to receive a physiotherapist treatment. **If your health status changes in the future, please let us know**. **Please notify the front desk if you have moved or if any of your personal information changes, as this affects your receipt for insurance submissions**. All the information gathered for this treatment is confidential, except as required or allowed by law, or to facilitate assessment or treatment by any Chiropractor at Active Chiropractic Family Health Centre. You will be asked to provide written authorization for release of any information. All payments are due prior to service. If you are covered by insurance, and your insurance does not cover any or part of a service you have received, you are liable for this fee.

Each therapist at Active Chiropractic requires 24 hours notice to cancel or reschedule an appointment as we often have a wait list for acute patients. Failure to do so will result in the full treatment fee being charged (please see our current fee schedule).

If you are covered by insurance:

Please note that you are liable for this cancellation fee and it will not be reimbursed by your insurance carrier. ..... Initials _____

I have read and I acknowledge any and all costs associated with my appointment. ..... Initials _____

Did you know that you can book your appointments online 24 hrs a day 7 days a week? **Ask us how**!

Name:		**Date:** DD/MM/YYYY
Street Address:		**City:**
Email Address:		**Postal Code:**
Courtesy reminder calls and emails: **Phone Call Reminders Y N** **Email Reminders Y N**		
Home Phone:	**Cell Phone:**	**Work Phone:**
Date of Birth: DD/MM/YYYY **Age:**	**Occupation:**	**Male** **Female**
Emergency Contact:	**ER Number:**	**ER Relationship:**

Have you ever been injured at work?

Is this a WSIB case? **If yes, please see front desk staff as we do not accept WSIB cases**

Is this a Motor Vehicle Accident case? **If yes, please speak with the front desk staff**

Current Medication(s) and condition it treats:

Primary Care Physician (Name/Address/Phone)

Are you currently receiving treatment from another health care professional? Yes No

If Yes, for what?

Have you ever had surgery? Yes No
If yes, Nature/Date(s):

Have you ever been hospitalized? Yes No
If yes, Nature/Date(s):

Other injuries: Yes No

If yes, Nature/Date(s):

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Do you have any internal pins, wires, artificial joints, or special equipment? Yes No
If yes, What?/Where?

Do you smoke? Yes No
If yes, how much: For how long?

Did you smoke in the past? Yes No
If yes, how much: For how long?

Please indicate conditions you are currently experiencing with a ✓, or ○ the conditions you have experienced in the past:

Respiratory
- ☐ Chronic Cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Family history of
- ☐ Respiratory difficulties

Cardiovascular
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Congestive heart failure
- ☐ Heart Attack
- ☐ Phlebitis/varicose veins
- ☐ Stroke / CVA
- ☐ Pacemaker / similar device
- ☐ Heart disease
- ☐ Family history of cardiovascular difficulties

Infections
- ☐ Hepatitis
- ☐ TB
- ☐ HIV
- ☐ Infectious Skin / Respiratory

Other conditions
- ☐ Loss of sensation
- ☐ Diabetes (Onset:_____)
- ☐ Allergies/Hypersensitivity (_____)
- ☐ Epilepsy
- ☐ Cancer
- ☐ Arthritis / Family history of
- ☐ Skin conditions _____
- ☐ Osteoporosis / Osteopenia
- ☐ Hemophilia
- ☐ Mental Illness/Nervous Disorder

Head/Neck
- ☐ Vision Problems
- ☐ Vision Loss
- ☐ Ear Problems
- ☐ Hearing Loss
- ☐ History of headaches / migraines

Women
- ☐ Pregnant (DUE:_____)
- ☐ Gynecological conditions, What?_____

Soft Tissue / Joint discomfort and its nature:
- ☐ Neck _____
- ☐ Low Back _____
- ☐ Mid Back _____
- ☐ Upper Back _____
- ☐ Shoulders _____
- ☐ Chest _____
- ☐ Arms _____
- ☐ Legs _____
- ☐ Knees _____
- ☐ TMJ _____
- ☐ Other: _____

Overall, how is your general health? (Circle below)

Excellent / Good / Fair / Poor

I have read the above information and have stated all my previous medical conditions. **I take it upon myself to update the Physiotherapist regarding any changes in my condition**. I understand that all physiotherapy treatments will be discussed and planned with the Physiotherapist, and will require my informed consent.

Furthermore, I authorize that the Physiotherapists providing care at Active Chiropractic Family Health Centre have full access to my client file.

Client Signature: _____ Date: _____

I consent to the sharing of my health history information, imagining and reports to the following practitioners of Active Chiropractic Family Health Centre: ____ Physiotherapist(s)_____Chiropractor(s) _____ Registered Massage Therapist(s) _____Naturopath(s) _____Fitness Trainer(s)

_____ _____
Signature **Date**

Active Chiropractic Health Centre will never sell, trade, rent exchange or otherwise share your personal information with any other person, company, or organization. Privacy is of paramount importance to us. The information you provide us including your name, address, phone numbers, email address, purchases, and credit card information is used to process your service order or registration, to answer your questions, and to send you periodic mailings about our services or upcoming events.

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CONSENT TO PHYSIOTHERAPY

When you attend Physiotherapy, you may be assessed and treated with hands on techniques including soft tissue and joint mobilizations. Treatment may also include stretching and strengthening exercises, and education on proper body mechanics and posture. Please make sure that you discuss with the physiotherapist if you have questions or concerns about any of the assessment or treatment procedures that may be carried out. You may withdraw consent for any procedure at any time by informing the physiotherapist. By signing below, you agree that you understand and consent to treatment. You may inform the physiotherapist at anytime if that consent changes.

I, _____, consent to physiotherapy assessment and treatment by Active
Patient (full name, printed)

Chiropractic's Physiotherapist.

- ☐ _____ Colleen Bourgeois, PT
- ☐ _____

_____ _____

Patient Signature (or Legal Guardian) Signature of Physiotherapist

Dated this _____ day of _____, 20 _____

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Family Health Centre

Under the Canada Anti-Spam Legislation (CASL), effective as of July 1, 2014, we require your consent in order to send you electronic communications; for example, the latest in exercises, nutrition information, class schedules, appointment reminders and any other information that may be of interest to you. To allow us to continue providing information that is relevant to you, please take a moment and check the boxes for the information that you would like to receive.

Active Chiropractic would not want you to miss out on any information that is beneficial to you.

First Name: _____

Last Name: _____

Email address: _____

	Appointment Reminders/Confirmation If you circled 'Yes' on the first page to receive appointment reminder emails please check the box		
	Clinic Newsletter		Massage Therapy
	Physiotherapy		Kinesiology - News
	Chiropractic-News		Personal Training
	Bootcamp		Nutrition Counselling
	Yoga		Naturopath Medicine
	Concussion Management		Counselling
	Running Clinics		
	I do NOT wish to receive ANY emails		

You may withdraw your consent or modify your subscription preferences at any time.

Dated this_____ day of_____, 20_____.

_____ _____

Signature **Name – please print**

Active Chiropractic Family Health Centre

_____ _____

Witness - Signature **Name – please print**