Active Chiropractic Family Health Centre

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

Physiotherapy Health History Form
MVA

For Your Information:
An accurate health history is important to ensure that it is safe for you to receive a physiotherapy 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 Physiotherapist 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 waitlist 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:**
Who referred you to Active Chiropractic?		
Date of Accident: DD/MM/YYYY **Time of Accident (Am/Pm):**		

Administrative Information Required Prior to your visit:

Insurance Coverage:

1. Is there other insurance coverage available? (ex. through work, spouse etc.) **YES or NO**
2. If **YES**, Are you the Insurance Policy Holder? **Y/N**
3. If **NO**, Who's Policy is it? _____
   What is the Policy #: _____
   Certificate #: _____
   Name of the Insurance Company:_____
   Phone #: _____
   Fax#:_____
4. Have you used any of your chiropractic benefits for this year? **YES or NO**
5. If **YES**, how much have you used? _____
6. Would you like us to submit to your extended health care on your behalf electronically? **Y/N**
7. If **Y**, please fill in the Electronic Submission Form❑

MVA Insurance:

1. Are you the Car Insurance Policy Holder? **YES or NO**
2. If NO, Who's Policy is it? _____
   What is the Policy #: _____
   Certificate #: _____
   Accident Claim#: _____
   Name of the Insurance Company:_____
   Name of Adjuster:_____
   Phone #: _____ Fax#:_____
3. A) Are you seeing any other practitioner for this MVA? **YES or NO**
   If **YES**, who is your Practitioner?_____
   B) Have you seen any other practitioner in the past for this current MVA prior to here? **YES or NO**
   If **YES**, who was your Practitioner? _____
4. Were you employed at the time of the accident? **Y/N**
5. Did you have any diseases/injury prior to the accident? **YES or NO**, please list_____

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Current Symptoms:

Please describe your current symptoms: _____

_____

_____

Are you currently suffering from any of the following (please circle):

RESTLESSNESS	IRRITABILITY	REDUCED TOLERANCE TO HEAT
DIFFICULTY CONCENTRATING	DIFFICULTY WITH MEMORY	REDUCED TOLERANCE TO ALCOHOL
SLEEPLESNESS	FORGETFULLNESS	

Please circle your current level of pain 1 2 3 4 5 6 7 8 9 10
1=no pain, 10=worst pain imaginable.

Immediate Details

Did you go to the hospital? YES or NO
If Yes, what was the name AND city of the hospital? _____
How did you get to the hospital? _____
What parts of your body were X-rayed at the hospital? _____
What did the hospital do for your injuries? _____

What bleeding cuts did you sustain during the accident? _____
What bruises did you sustain during the accident? _____
Did you receive any bruises from the seat belt? YES or NO
If yes, please describe _____
Did you lose consciousness (blackout) upon impact? YES or NO
Did you experience a flask of light or explosion in the head? YES or NO

From the accident, did you become (please circle)

CONFUSED	DISORIENTED	LIGHTHEADED	DIZZY
BLURRED	VISION	NAUSEATED	RINGING/BUZZING IN THE EARS

If you still have any of the symptoms, which ones? _____

Accident Details

Please Describe, to the best of your knowledge, what happened during this accident:

_____

_____

_____

Road conditions at the time of the accident? **WET DRY ICY OTHER**: _____
Where were you seated in the vehicle? _____
Where you wearing a seatbelt? **YES or NO**
If Yes, was it a lap seatbelt_____ shoulder-lap seatbelt_____
Did your vehicle's airbag deploy? **YES or NO**
Where you aware of approaching collision prior to impact, or did the impact catch you by surprise?
AWARE_____ SURPRISE_____
Was your head pointing forward at the moment of impact? **YES or NO**
If NO, how was it turned? _____
Does your vehicle have a head rest? **YES or NO**
If YES, how far is it above the seat back? _____ Inches

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Was your car stopped at the time of impact? **YES or NO**
If YES, was the driver's foot also on the brake? **YES or NO**
If NO, then estimate the speed of the vehicle you were in:_____kph
If your vehicle was moving at the time of impact, was it:
Slowing down_____gaining speed _____travelling at a steady rate of speed_____

On what part of the automobile did your following body parts hit?
Head hit_____ Chest hit_____
Right/left shoulder hit_____ Right/left arm hit_____
Right/left hip hit _____ Right/left leg hit_____
Right /left knee hit _____ Other_____

Which of the following car parts broke during the accident? Please Circle
Windshield Front Sheet
Right/left side window Other_____
Steering Wheel Other_____

Approx. Damage to vehicle? Totalled or Smashed

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):

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?

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Please indicate conditions you are <u>currently</u> experiencing with ☑ or ○ the conditions you <u>have</u> 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.

Patient 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: ____ Chiropractor(s) _____ Registered Massage Therapist(s) _____ Physiotherapist(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, MsPT
☐ _____

_____ _____
Patient Signature (or Legal Guardian) Signature of Physiotherapist

Dated this _____ day of _____, 20 _____

Active Chiropractic
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
	Chiropractic – News		Kinesiology - News
	BootCamp		Personal Training
	Yoga		Nutrition Counselling
	Running Clinics		Physiotherapy
	Counselling		Concussion Management
	Naturopathic Medicine		
	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**

_____ _____

Witness - Signature **Name – please print**

Electronic Transmission Authorization and Consent Form

This form must be filled out prior to claims submitted electronically by the provider on your behalf. This form must be retained in your patient file for verification purposes for two years following closure of your patient file.

Provider: **Active Chiropractic Family Health Centre**
Address: **1169 Pembroke Street, East**
City/Province: **Pembroke, Ontario**
Postal Code: **K8A 7R4**
Phone Number: **613-732-9215**

Patient: _____
Address: _____
City/Province: _____
Postal Code: _____
Phone Number: _____
Plan Number: _____
Certificate / Plan member Number: _____

Consent to Collect and Exchange Personal Information

Message to the Plan member, Spouse and/or Dependent regarding Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.
I authorize the insurer and / or plan administrator and their service provider(s) to:

- use my personal information for the above purposes.
- exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law(s).
I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

_____
Date

_____ _____
Print - Name Signature

_____ _____
Witness - Print Witness – Signature