

**Please answer all questions**

**Full Name:** \_\_\_\_\_

**Date of Birth (MM/DD/YYYY):** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Address:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Province:** \_\_\_\_ **Postal Code:** \_\_\_\_\_

**E-Mail:** \_\_\_\_\_

**Emergency Contact:**

**Occupation:** \_\_\_\_\_

**Name:** \_\_\_\_\_

**Insurance Information:**

**Relation:** \_\_\_\_\_

**Name of Insurance Company:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_

**Group/Policy/Plan #:** \_\_\_\_\_

**Family Doctor:** \_\_\_\_\_

**Member ID:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Are you the plan Member:**  Y  N **If No,**

**Phone #:** \_\_\_\_\_

**Plan Member Name:** \_\_\_\_\_

**Reason(s) for Physiotherapy**

**Medical History**

**Area of Injury of Pain:** \_\_\_\_\_

**Yes No**

**Diagnosis:** \_\_\_\_\_

Do you have **Diabetes?**

**If injury,**

Do you have **Hypertension or Heart Disease?**

**Type of Injury:**  MVA  Work  Sports  Other

Do you have a **Pacemaker?**

**Date of Injury (MM/DD/YYYY):** \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you have **Epilepsy?**

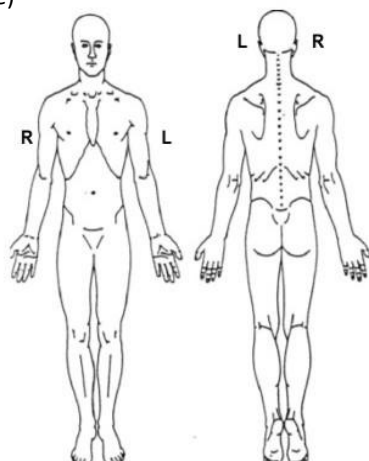
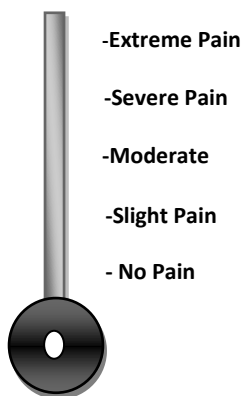
If you are female, Are you **Pregnant?**

Do you have **Asthma or Other**

**Pain Intensity Meter: Indicate the Location of Your Pain**

**Respiratory illness**

(Please Circle One)



Have you had **Major Surgery** or

**Serious Illness/Condition?**

**Please List:** \_\_\_\_\_

Do you have **Allergies/Sensitivities** to:

**Drugs, Tape, Creams, Heat or Cold?**

**Please List:** \_\_\_\_\_

Do you have **Metal Implants** in your body

**Please Describe:** \_\_\_\_\_

**Medications: Please List:** \_\_\_\_\_

**Referral source to our clinic:**  Family Physician  Specialist  Yellow pages  Sign  Insurance

Friend/Family  Website  Google  Other: \_\_\_\_\_

**Consent for Physiotherapy Assessment and Treatment**

I, the undersigned do hereby give my voluntary consent to the Physiotherapists at Bloor Jane Physiotherapy to conduct a musculo-skeletal assessment and to administer any appropriate treatments by my treating physiotherapist and the support staff. I understand that the goals of physiotherapy treatments are to help reduce my pain and improve my mobility, strength, endurance, function, and quality of life. I consent to individual treatments applications after I have been given information regarding the nature of the treatment, its expected benefits, and any side effects. I will respond by giving my verbal consent. I also understand that some treatment services may be administered by the Physiotherapy Assistant (PTA) under the supervision of the Physiotherapist. Furthermore, I understand that I can withdraw my consent at any time without any negative consequences.

**Missed Appointment and Cancellation Policy**

We understand that situations arise in which you must cancel your appointment at times, we therefore request that if you must cancel, you provide 24hrs notice. This will enable another client who is waiting for an appointment to be scheduled in. With cancellation less than 24hrs we may be unable to offer that time to other patients. Appointments cancelled with less than 24 hrs notification will be subjected to a \$40.00 cancellation fee. Be aware that your extended health insurance or motor vehicle insurer will not pay for this charge. Our practice firmly believes that good therapist/patient relationships are based upon good communication and mutual respect. By signing below, you confirm that you have read and agree to this cancellation and no-show policy.

**Consent for Payment**

I understand that Bloor Jane Physiotherapy is a private clinic that practices outside the OHIP plan and services rendered to patients with MVA or WSIB claim will be billed directly to insurance companies. Private patients with eligibility to EHCs will be billed with authorization to relevant insurance and patients are responsible for any payments not reimbursed by your insurance for services rendered. Official receipts will be provided upon remittance of payment.

**Medical Release Consent**

I authorize Bloor Jane Physiotherapy to release to my insurance company and/or rehabilitation consultant and/or referring physician any and all information they may require pertaining to my physiotherapy treatment, including reports, progress notes and account details.

**Privacy Policy**

I understand that to provide me with physiotherapy services, Bloor Jane Physiotherapy will collect some personal information about me. I have reviewed Bloor Jane Physiotherapy's Privacy Policy (available upon request) about the collection, use and disclosure of personal information, steps taken to protect the information and my rights to review my personal information. I understand how the Privacy Policy applies to me. I agree to Bloor Jane Physiotherapy collecting, using, and disclosing personal information about me as set out in their Privacy Policy.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_