Physiotherapy Intake Form

Date: _____

PATIENT INFORMATION

Name _____ Cell Phone # _____

Email _____ Home Phone # _____

Date Of Birth _____ AHC # _____

Address _____ City _____

Family Doctor _____ Postal Code _____

Emergency Contact Name _____ Phone # _____

Referral Source:

☐ Google ☐ Doctor ☐ Social Media ☐ Family/Friend

Whom can we thank for this referral? _____

PRIVATE INSURANCE

Do you have any private insurance / benefits? ☐ Yes ☐ No

Primary Insurance Company: _____ Policy/Group #_____

Insurance Renewal Month: _____ ID #_____

Plan Member Name: _____

DOB of Plan Member: _____ Relationship to Plan Member: _____

Secondary Insurance Company: _____ Policy/Group #_____

Insurance Renewal Month: _____ ID #_____

Plan Member Name: _____

DOB of Plan Member: _____ Relationship to Plan Member: _____

WCB

Is this injury a WCB claim? ☐ Yes ☐ No

Claim #_____ Date of accident _____

MVA

Is this injury from a Motor Vehicle Accident? ☐ Yes ☐ No

Insurance Company _____ Insurance Phone # _____

Fax # _____ Date of Accident _____

Adjuster Name _____ Adjuster Email _____

Claim # _____ Policy # _____

I understand that if my MVA claim is NOT accepted, I am responsible for any fees related to my treatments (**Initial**): _____

HEALTH & LIFESTYLE INFORMATION

Do any of the following conditions apply to you?

☐ Osteoporosis	☐ Inflammatory illnesses	☐ Arthritis
☐ Anemia/blood disorders	☐ HIV/AIDS	☐ Diabetes
☐ Unexplained weight loss/gain	☐ Fainting/dizziness	☐ Currently pregnant
☐ Bladder incontinence	☐ Respiratory problems	☐ Cancer

☐ Cardiac problems (high blood pressure, heart disease, pacemakers, etc.)
☐ Neurological conditions (stroke, seizures, epilepsy, etc.)
☐ Other: _____

Please describe your symptoms of the present injury as best you can:

_____

_____

_____

Does this condition interfere with your daily life? (If yes, please explain)

_____

_____

_____

POLICIES & CONSENT

Cancellation Policy:

We are here to provide you with the very best care and attention. Your treatment time is reserved just for you. In our commitment to provide an outstanding experience to all our patients, and out of consideration for our physiotherapist's time, we will be enforcing a cancellation and no-show policy. **A minimum of 24 hours is required for cancellations or a $50.00 cancellation fee will be charged to your account.** As a courtesy to our patients, if you arrive late, your appointment will be shortened to the remainder of your original scheduled appointment.

Physiotherapy Consent:

Physiotherapy involves many different types of physical evaluation and treatment. As with all forms of medical treatment, there are benefits and risks involved with physiotherapy. The physical response to treatment varies and cannot always be predicted as every individual is different. There is no guarantee that the treatment will help the condition you are seeking treatment for and there is a risk that treatment will cause some discomfort or aggravation of the existing condition.

During your physiotherapy visit, it is often necessary to expose and touch the area in need of treatment. At times, the practitioners may ask you to remove some items of clothing to facilitate treatment. If you do not feel comfortable with any part of the treatment, please tell us immediately. Every effort is made to preserve modesty and keep you comfortable. Please communicate to your therapist and the operations manager if you have any other concerns during the treatment. Physiotherapy, as with any type of medical care, is the most effective if you participate according to the treatment plan agreed upon with your therapist. If at any time you have questions regarding treatment and services provided, please do not hesitate to talk to your therapist.

By signing this, I hereby:

- **authorize the release of all necessary information to my primary care provider and/or referring physician.**
- **understand the cancellation policy and acknowledge the potential charges for late cancellations or no-shows.**
- **have read this form and agree to all consent regarding physiotherapy evaluation and treatment.**

Patient/ Legal Representative Signature: _____

Name: _____ Dated: _____

Physiotherapist: _____ Dated: _____

DRY NEEDLING

Dry needling is a form of therapy in which fine needles are inserted into specific parts of the body. Dry needling is generally very safe. Serious side effects are very rare, less than 1 per 10,000.00. You need to be aware that:

- Drowsiness may occur after treatment in a small number of patients and if affected, you are advised not to drive.
- Minor bleeding or bruising may occur after treatments.
- Existing symptoms can get worse after treatment (less than 3% of patients). You should tell your physiotherapist about this.
- Soreness is a common occurrence with dry needling.
- Fainting can occasionally occur in certain patients, particularly at the first treatment.
- Single-use, disposable needles are always used in this clinic.

Please identify if any of the following questions apply to you:

Are you diabetic?	☐ Yes	☐ No
Do you have a history of fainting or an aversion to needles?	☐ Yes	☐ No
Do you have a bleeding disorder?	☐ Yes	☐ No
Are you taking anticoagulants (blood thinners) or any other medication?	☐ Yes	☐ No
Do you have damaged heart valves?	☐ Yes	☐ No
Do you have any conditions putting you at an increased risk of infection?	☐ Yes	☐ No
Are you pregnant or actively trying to get pregnant?	☐ Yes	☐ No
Do you have any metal allergies?	☐ Yes	☐ No
Are you aware of any reason why you should not have dry needling?	☐ Yes	☐ No

By signing this, I hereby:

- **recognize the potential risks of dry needling treatments.**
- **confirm that I have read and understood the above information.**
- **consent to having acupuncture treatment.**

Patient/ Legal Representative Signature: _____

Name: _____ Dated: _____

Physiotherapist: _____ Dated: _____