



# 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? \_\_\_\_\_

## 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?**

- |                                                                                                  |                                                 |                                             |
|--------------------------------------------------------------------------------------------------|-------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Osteoporosis                                                            | <input type="checkbox"/> Inflammatory illnesses | <input type="checkbox"/> Arthritis          |
| <input type="checkbox"/> Anemia/blood disorders                                                  | <input type="checkbox"/> HIV/AIDS               | <input type="checkbox"/> Diabetes           |
| <input type="checkbox"/> Unexplained weight loss/gain                                            | <input type="checkbox"/> Fainting/dizziness     | <input type="checkbox"/> Currently pregnant |
| <input type="checkbox"/> Bladder incontinence                                                    | <input type="checkbox"/> Respiratory problems   | <input type="checkbox"/> Cancer             |
| <input type="checkbox"/> Cardiac problems (high blood pressure, heart disease, pacemakers, etc.) |                                                 |                                             |
| <input type="checkbox"/> Neurological conditions (stroke, seizures, epilepsy, etc.)              |                                                 |                                             |
| <input type="checkbox"/> Other: _____                                                            |                                                 |                                             |

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

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

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## 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 50% of the service 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?                                                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a history of fainting or an aversion to needles?              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a bleeding disorder?                                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you taking anticoagulants (blood thinners) or any other medication?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have damaged heart valves?                                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have any conditions putting you at an increased risk of infection? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you pregnant or actively trying to get pregnant?                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have any metal allergies?                                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Are you aware of any reason why you should not have dry needling?         | <input type="checkbox"/> Yes | <input type="checkbox"/> 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: \_\_\_\_\_