WELCOME NEW PATIENT

First & Last Name

Address

City Postal Code

Telephone (B) (H) Fax

Email

Date of Birth

Day Month Year

Doctor Telephone

How did you hear about Personal Best?

❑ Family Physician ❑ Specialist ❑ Friend ❑ Advertisement ❑ Other

RELEASE OF INFORMATION

By signing this form, I authorize Personal Best Physiotherapy to obtain/ release medical information pertaining to myself

Please write the name of your doctor, WCB, Insurance Co., Rehabilitation Co. above

❑ **I understand that 24 hour notice for any change or cancellation to my appointment is required or charges will apply for the appointment.**

Patient Signature Date

This Clinic is not covered by WCB or OHIP

MOTOR VEHICLE ACCIDENT

If you have been involved in a motor vehicle accident, please fill in this section

Name of Insurance Company

Address of Insurance Company

Claim number

Insurance Agent's Name

Insurance Agent's Telephone

HEALTH CONSENT FORM

We want your informed consent. This means that we want you to understand the services we provide and how we use your personal information.

ASSESSMENT AND TREATMENT

I consent to assessment by a member of the clinical staff at *Personal Best Physiotherapy*. I am responsible for deciding whether to follow the recommendations made by a clinician. I understand that I may not respond to treatment recommended. I understand that I may ask questions related to my conditions, assessment results and treatment recommendations.

COLLECTION AND USE OF PERSONAL INFORMATION

I understand to complete my assessment and provide services, staff will collect some personal information about me. I agree to *Personal Best Physiotherapy* collecting, using and disclosing personal information about me as required to my physician, allied health care providers involved in my care, insurance provider or third parties payers if applicable.

INFORMATION ON THE COST OF OUR SERVICES

WSIB/OHIP does not cover any of our services. In some cases extended health insurance will cover the costs. It is the patient's responsibility to verify their insurance coverage.

CLINIC FEES

Physiotherapy/Pilates Rehabilitation with a Registered Physiotherapist

- Assessment 60 minutes $125.
- Follow Up 45 minutes $90.
- Follow Up 30 minutes $70.

Physiotec program/exercise addition $5. per session added to the above fees.
HST is not applicable to physiotherapy services.

Private Pilates Sessions with a Certified Pilates Instructor

- 60 minutes $85 + HST = $96.05

Post Rehab Exercise Session with Registered Kinesiologist

- 60 minutes $80 + HST = $90.40

Forms, Letters, Telephone consultations

- Basic $25. + HST

The patient is responsible for full payment to *Personal Best Physiotherapy* for goods and services provided at the end of each appointment.

Today's Date

Patient Signature

Patient Name *print clearly*

If the patient has a legal guardian, please provide

Legal Guardian Signature

Legal Guardian Name *print clearly*

PHYSIOTHERAPY AND YOU

Please briefly write in your own words the primary reason for your Physiotherapy consult *e.g. back & leg pain*

Have you been to physiotherapy in the past? ❑ Yes ❑ No
If yes, briefly explain for what condition and type of therapy *e.g. manual therapy, machines, exercises*

Are you currently taking any medication? ❑ Yes ❑ No

Please list

Have you had any surgeries in the past? ❑ Yes ❑ No

Please list

Do you currently have or have a history of any medical condition(s)? Please check all that apply

- ❑ Diabetes
- ❑ Stroke
- ❑ Kidney problems
- ❑ High blood pressure
- ❑ Respiratory / lung problems
- ❑ Fibromyalgia
- ❑ Shortness of breath
- ❑ Insomnia/difficulty sleeping
- ❑ Headaches
- ❑ Dizziness
- ❑ Depression
- ❑ Recent infection *eg. chest, urinary tract*
- ❑ Broken bones/fractures
- ❑ Skin diseases
- ❑ High cholesterol
- ❑ Cancer
- ❑ Osteoporosis
- ❑ Incontinence / lack of bladder control
- ❑ Pace maker
- ❑ Heart disease
- ❑ Heart attack
- ❑ Thyroid problems
- ❑ Wrist/hand pain
- ❑ Knee pain
- ❑ Neck pain
- ❑ Jaw pain
- ❑ Shoulder pain
- ❑ Hip pain
- ❑ Low back pain
- ❑ Ankle/foot pain
- ❑ Mid back pain

❑ Allergies:

❑ Other

Do you currently or have a history of being a smoker? ❑ Yes ❑ No

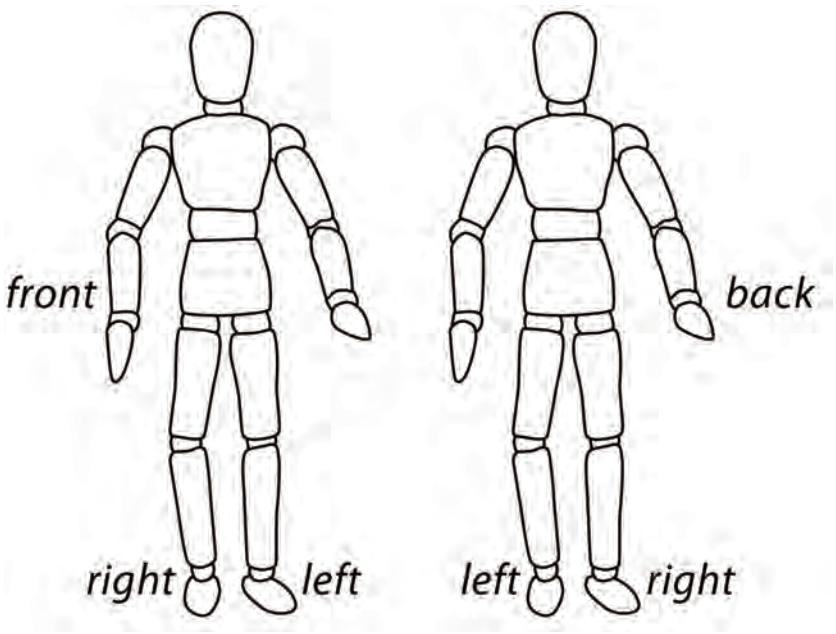
Have you had any of the following medical images? ❑ Yes ❑ No

Please list including for what condition

❑ X-ray ❑ Diagnostic ultrasound ❑ CT scan ❑ MRI ❑ Other

COMPLAINTS & SYMPTOMS

Please identify on diagram where experiencing symptoms and what type example:
pins & needles, stabbing pain, burning pain, achey pain or other



PAIN BEHAVIOUR

Select all that apply:

My pain is

❑ improving ❑ worsening

❑ the same ❑ constant

❑ intermittent - comes and goes

What activities/movements make your pain

Worse

Better

PAIN SCALE

How severe are your symptoms?

❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

No pain — Unbearable pain

Please tell us what your 3 primary goals are or what you wish to achieve with your Physiotherapy treatments *e.g. return to playing tennis 3X/week, be able to walk for 30 minutes, eliminate headaches*

FOR FEMALE PATIENTS ONLY

Are you currently pregnant or think you might be pregnant? ❑ Yes ❑ No

THANK YOU for taking the time to share this information with us.

Personal Best PHYSIOTHERAPY PILATES · REHABILITATION

An active hands-on approach through rehabilitation pilates

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fax 416 642 0092 Call to book an appointment 416 322 6070