INITIAL INTAKE FORM

Please print clearly

Last Name:	First Name:	Middle Name:	Sex: ❑ M ❑ F	Date of Birth: DD/MMM/YYYY

Street Address:	Unit or Apt #:	City:	Province:	Postal Code:

Cell Phone Number:	Home Phone Number:	Work Phone Number:

E-Mail Address:	Occupation:

Emergency Contact Full Name:	Phone Number:	Relationship:

How did you hear about us?

❑ Doctor Referral: _____ ❑ Patient Referral: _____ ❑ Other: _____

❑ Website ❑ Social Media ❑ Advertisement ❑ Search Engine ❑ Yellow Pages

Family Doctor:	Phone Number:	Practice Location:

Current Medications:

Please list and date any Surgeries:

Please list the presence of any internal pins, wires and artificial joints:

Is this Condition: ❑ Motor Vehicle Accident (MVA) ❑ Workplace Injury (WSIB) ❑ Sports Injury ❑ Other: _____

What is your Chief Complaint:

Any other areas of Concerns:

How long have you had your present pain?

Did your present pain begin with a specific incident?

❑ No ❑ Yes (if yes please explain)

Please rate your pain level on the chart below:

1	2	3	4	5	6	7	8	9	10

No Pain *Very Painful*

Have you had this problem before?

❑ No ❑ Yes (if yes, how often and how long does the pain last?)

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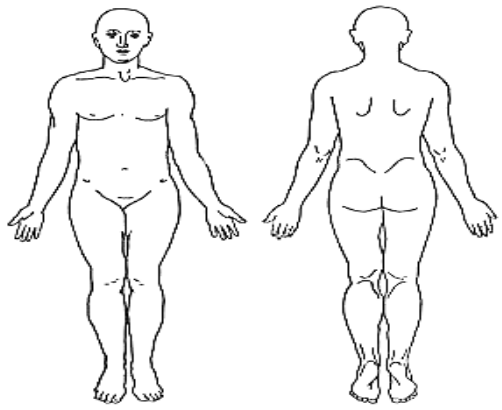
INDICATE AREAS OF PAIN OR DISCOMFORT

Mark the areas on the bodies where you feel the described sensations. Indicate areas of:

Numbness))))
Pins & Needles OOOO
Burning XXXX
Aching ****
Stabbing ////



MEDICAL HISTORY

MUSCULOSKELETAL

- ❑ Bone or Joint Disease
- ❑ Tendonitis
- ❑ Bursitis
- ❑ Fractures
- ❑ Osteoporosis
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Sprains/Strains
- ❑ Swelling
- ❑ Stiffness
- ❑ Headaches
- ❑ Migraines
- ❑ Spasms/Cramps
- ❑ Pain (check area):
  __Jaw __Neck __Shoulder __Elbow
  __Wrist __Hip __Ankle __Knee
  __Back __Foot __Toes
- ❑ Other: _____

OTHER

- ❑ Drug/Alcohol addiction
- ❑ Nicotine/Caffeine addiction
- ❑ Diabetes
- ❑ Vision/Hearing Loss
- ❑ Headaches/Migraines
- ❑ Cancer
- ❑ Epilepsy
- ❑ Allergies (please list)
- ❑ Other: _____

CARDIOVASCULAR

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chronic Heart Failure
- ❑ Heart Disease
- ❑ Myocardial Infarction
- ❑ Phlebitis
- ❑ Cardio-Vascular Accident
- ❑ Stroke
- ❑ Pacemaker
- ❑ Varicose Veins
- ❑ Blood Clots
- ❑ Osteoarthritis
- ❑ Lymphedema
- ❑ Other: _____

NERVOUS SYSTEM

- ❑ Herpes/Shingles
- ❑ Numbness/Tingling
- ❑ Chronic Pain
- ❑ Fatigue
- ❑ Sleep Disorder
- ❑ Loss of Sensation
- ❑ Other: _____

INFECTIOUS DISEASES

- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ HIV
- ❑ Other: _____

DIGESTIVE

- ❑ Constipation
- ❑ Gas/Bloating
- ❑ Nausea/Vomiting
- ❑ Irritable Bowel Syndrome
- ❑ Liver/Gall Bladder
- ❑ Kidney/Bladder
- ❑ Other: _____

RESPIRATORY

- ❑ Chronic Cough
- ❑ Bronchitis
- ❑ Shortness of Breath
- ❑ Asthma
- ❑ Emphysema
- ❑ Smoking
- ❑ Other: _____

SKIN

- ❑ Allergies (anaphylactic)
- ❑ Rashes
- ❑ Athletes Foot
- ❑ Warts
- ❑ Cold Sores
- ❑ Eczema/Psoriasis
- ❑ Other: (contagious) _____

REPRODUCTIVE

- ❑ Pregnancy (trimester_____)
- ❑ PMS
- ❑ Other: _____

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INSURANCE INFORMATION

Do you have Extended Health Insurance? ❑ NO ❑ YES *if YES, you will be required to complete a Benefit Assignment Form AND an Electronic Transmission Authorization & Consent Form

IF FOR ANY REASON YOUR EXTENDED HEALTH CLAIM IS NOT APPROVED OR DOES NOT PAY IN FULL, YOU ARE RESPONSIBLE FOR ALL REMAINING CHARGES

CREDIT CARD INFORMATION

optional

Method of Payment: ❑ Visa ❑ MasterCard	Name as it appears on the credit card:
Card Number:	Expiry Date:

I, _____ (name of card holder), authorize:

❑ Progressive Sports Medicine ❑ Total Health Link ❑ Elite Physiotherapy Clinic

to charge my credit card above for the agreed upon fees and/or charges. I understand that my information will be saved to file for future transactions on my account and that this authorization will remain in effect until cancelled. I understand that I may cancel this authorization at anytime by contacting the clinic.

_____ _____

Cardholder Signature **Date**

CANCELLATION POLICY

OUR CLINICS POLICIES REQUIRE 24 HOURS NOTICE TO CANCEL AN APPOINTMENT

We understand that occasional missed appointments can occur for a variety of reasons. While the clinics do provide regular appointment reminders via email, patients acknowledge that they are responsible for their attendance and that 24 hours notice is required should they wish to cancel or reschedule their appointment. This time frame gives our therapists an opportunity to fill the spot with another patient in need of care.

We reserve the right to charge for late cancellations (less than 24 hours) and/or missed appointments as follows:

- 1st and 2nd occurrence – a reminder of this policy will be emailed to the patient and no charges will apply
- 3rd occurrence – a $30.00 late cancellation/missed appointment charge will be added to the patients account
- 4th occurrence – the full appointment fee will be added to the patients account
- 5th occurrence – the patient will be required to pre-pay for all future appointments

Cancellation/Missed Appointment fees are payable at or before the next appointment. Extended health benefits or any other type of insurance coverage cannot be billed to settle your account for cancellation fees or unattended appointments.

RELEASE OF MEDICAL INFORMATION

I hereby authorize: ❑ Progressive Sports Medicine ❑ Total Health Link ❑ Elite Physiotherapy Clinic

and/or its employees or agents to be permitted to obtain and review copies of all medical, hospital, clinical, and practitioner's notes; employment, vocational, and insurance documents, including full and final or other releases, and any other related records or documents, and to share or discuss pertinent information with appropriate qualified medical & paramedical professionals, coaches and/or their affiliates or others involved in my treatment, rehabilitation, claims or representation.

I hereby give my permission to share the information received with any other duly authorized individuals or parties acting in accordance with my representative's permission. 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 clinic(s).

I acknowledge that the information I am providing is accurate and complete.

_____ _____ _____

Patient Full Name (please print) **Patient Signature** (or Legal Guardian) **Date**

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