



Name: _____ Date of Birth: _____
Cell: _____ Home: _____ Email Address: _____
Mailing Address: _____

Medical History: (ie. surgeries, accidents/injuries, conditions, cancer) _____

Current Medication (s): _____

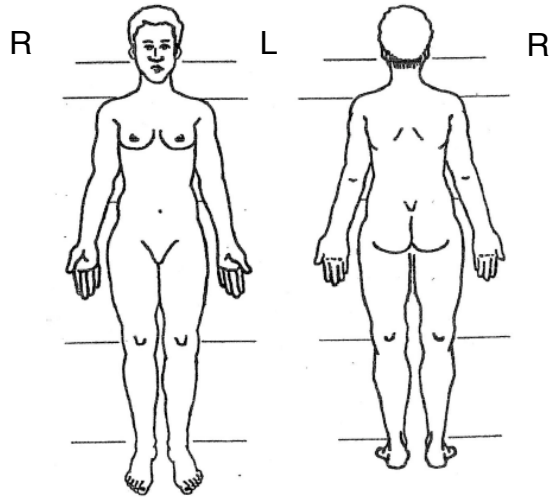
Emergency Contact (Name & Phone Number) _____

Family Physician (name) _____

Select visit type:

Physiotherapy Massage Therapy

Reason for Today's Visit? -you can use the diagram to indicate your problem area(s): _____



GOALS OF TREATMENT:

What are you hoping to achieve during or through your physiotherapy or massage therapy sessions? _____

If your injury is interfering at all with your ability to work or play, please indicate

Employment: _____ Leisure Activities: _____

Consent to treatment:

When you attend Physiotherapy and/or Massage Therapy you may be treated with soft tissue techniques and manual therapy techniques. Your Therapist may have you perform exercises, may use modalities, education and even acupuncture or IMS. Please ensure you discuss with your therapist if you have questions or concerns about any of the assessment or treatment procedures that will be or are being performed. You may withdraw consent for any procedure at any time by informing your therapist. Please initial this to say you understand that you are consenting to treatment and that you will inform your therapist at anytime if that consent changes _____ (initial)

New Patient Intake Form

Privacy Policy:

All written records of physiotherapy and massage therapy sessions are kept strictly confidential and will not be shared with any outside establishment, individuals, organizations or medical facilities without explicit written consent from the client (you) or the client's legal guardian. _____ (initial)

Cancelation Policy:

We appreciate 24hrs notice for cancelations.

Reach Physio Solutions reserves the right to charge the full amount for appointments missed or rescheduled with less than 24hrs in advance if the spot does not get filled. _____ (initial)

We like to make sure you won't miss any of your appointments, in this sometimes busy world, it can be easy to forget. Please choose ONE option below indicating how you would like to be reminded:

- Email 2 days before
- Phone call the day before and an email 2 days before
- NO REMINDER NEEDED

We like to know how our clients find there way to our practice...

please tell us *who* sent you our way (they might even get a cool gift, or at least a THANK-YOU from us!) _____

NOTE if we are billing a 3rd Party: Even though we bill various companies on your behalf, if they refuse to pay, **you are responsible for the charges.** It is your responsibility to be aware of your coverage restrictions/limits otherwise you may be facing a large bill down the road. Even with 100% coverage, you may have a "cap" or there may be a deductible and this will need to paid by the policy holder.

In exchange for doing direct billing, we ask that you leave a credit card number on your account, to be used in case we don't get reimbursement from your insurer and we don't see you again ;-). We will make every attempt to notify you if/when your billings are not accepted and give you fair notice that we are going to bill your credit card instead. If we are billing on your behalf, please initial that you have read the above: _____ (initial)

I verify that all i understand and agree to all the above and that all information provided is correct to the best of my knowledge.

Singnature _____ Date _____

If Patient is under 18 years of Age:

Name of Parent or Guardian: _____ Signature : _____

THANKS FOR VISITING US
Sincerely,

The Reach Physio Team

Sue Shalanski BScPT CGIMS

Karen Ogilvie BScPT CAFCI CGIMS

Angela Newton BScKin MScPT CAFCI

Patrick McKinnon BScKin MPT

Donna McMurtry BSc RMT

Mike Charuk RMT Rolfling

Maggie Phillips-Scarlett MKin MPT