Patient Intake Form

Name:_____Date of Birth_____

Cellphone number:_____ Home phone:_____

Email address:_____

Mailing address:_____

Emergency Contact (name & phone number):_____

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

_____

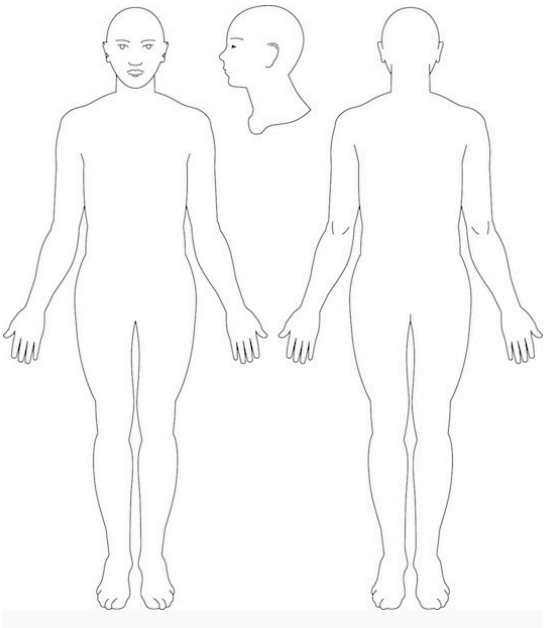
_____

Family Physician (name): _____

Select visit type:

O Physiotherapy O Massage Therapy

O Real Time Ultrasound Assessment



Reason for Today's visit?_____

_____

You can use the diagram on the right to indicate your problem area(s)

Goals of treatment: *What are you hoping to achieve during or through your therapy session(s)?*

Is your injury interfering with your ability to work or play?

Please describe: _____

_____

_____

Consent to treatment:

Treatment techniques may include, but are not limited to: soft tissue techniques, manual techniques, spinal manipulation, electrotherapeutic modalities and exercise as well as other techniques such as acupuncture or IMS. A number of these may be recommended during your program. It is our policy to ensure that benefits, side effects and potential complications of each chosen modality are explained to you before use. Please ensure that you discuss with your therapist about any concerns and questions you may have about any of the assessment or treatment procedures that will be performed immediately so they can explain the treatment rationale and/or modify your program appropriately. You may withdraw consent for any procedure at any time by informing your therapist. Please initial this to say that you understand that you are consenting to assessment and treatment and that you will inform your therapist at any time if that consent changes. _____ (initials)

Privacy Policy:

All written records of physiotherapy and massage therapy sessions are kept strictly confidential ad 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. _____ (initials)

Note: *Your email address and any contact details will not be shared with any third parties either!

Fees & Cancellation Policy:

Physiotherapy rates:	$60/half hour	$80/forty-five minutes	$110/hour
Massage rates:	$55+HST/half hour	$75+HST/forty-five minutes	$90+HST/hour

I acknowledge that if I fail to provide a minimum of 24 hours notice of a cancellation, it is my responsibility to pay for my appointment in full. _____ (initials)

To ensure that you won't miss your appointments, automatically generated emails are sent 2 days before your upcoming appointment, giving you plenty of time to reschedule or cancel if need be.

NOTE REGARDING 3rd Party/Insurance Billings:

If we are billing a third party/insurance company on your behalf, should they refuse to pay, YOU ARE RESPONSIBLE FOR ALL CHARGES. It is your responsibility to be aware of your coverage restrictions/limits otherwise you may be faced with a large bill along the way. Even with 100% coverage, you may have a cap or there may be a deductible required, this will need to be paid by the policy holder. **Please initial that you understand that these charges could be your responsibility if your insurance/3rd party doesn't cover you**. _____ (initials)

We are not required to bill third parties on your behalf, this is a courtesy service. If we fail to be reimbursed successfully from certain 3rd parties/insurance plans, this service may be discontinued without notice.

We DO NOT ACCEPT WCB/Worksafe BC cases.

Regarding Ultrasound Imaging of Skeletal Muscles:

Your therapist may want to help you relearn to use your muscles again using ultrasound imaging, the same tool used to look at unborn children and organs etc. Ultrasound has no known adverse effects but it is a form of energy with a potential to produce a biological effect on tissue and should be used with care, as if there is a risk (even though it is very small). If you are pregnant please notify your therapist. Should any unforeseen abnormality be seen while scanning your muscles, you will be advised to see your family physician. A letter will be sent by your therapist explaining the reason for the referral. **Physiotherapists are NOT trained to give you any diagnosis.**

I give my consent to have the imaging done. I am NOT pregnant and I that I have been informed of the risks and agree to the procedure for reporting unforeseen abnormalities. _____(initials)

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

Signature: _____ Date:_____

If patient is under 18 years of age,
Name of Parent/guardian: _____ Signature:_____