ADVANCE PHYSIOTHERAPY CLINIC

171 Advance Blvd. Unit 3
Brampton, ON L6T 4Z6
Tel: 905 792 7424
Fax: 905 792 7425

Client Intake Form

Name: _____ **Date of Birth:** _____/_____/_____
Last First Year Month Day

Address: _____/_____/_____
Street City Postal Code

Phone #: Home _____ **Cell**_____ **Work**_____
(Please circle the best telephone number that you can be reached at during the day)

Gender: Male/Female Family Doctor: Name_____ **Phone #**_____

Occupation: _____ **Email Address:** _____

Would you like to receive email reminders for future appointments? (Please initial): YES_____ NO_____
*By indicating yes you authorize our scheduling software to send you reminder emails automatically the day before your appointment

Emergency Contact:_____ **Relation:**_____ **Phone #:**_____

For office use only- health card/driver's license #: _____

If your injury is Motor Vehicle Accident (MVA) related, please fill out this section:

Insurance Company:_____

Claim #:_____ Policy #:_____ Date of MVA:_____

Adjuster Name: _____ Phone #:_____
Last First

Fax #:_____ Policy Holder:_____
Last First

If you have any extended benefits/insurance, please fill out this section:

Insurance Company:_____

ID/ Certification #:_____ Policy/Contract #:_____

Policy Holder Name:_____
Last First

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Medical History for (name):_____

Please check the boxes to indicate any condition(s) you have experienced or are experiencing:

CARDIOVASCULAR:
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Congenital heart defects
- ☐ Congestive heart failure
- ☐ Heart disease
- ☐ Heart attack
  - Date:_____
- ☐ Stroke/CVA
  - Date:_____
- ☐ Anemia
- ☐ Bleeding disorders
- ☐ Blood clots
- ☐ Phlebitis
- ☐ Varicose veins
- ☐ Pacemaker or similar device
- ☐ Other:_____

BONE HEALTH
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Arthritis
- ☐ Scoliosis
- ☐ Disc herniation
- ☐ Bone disease
- ☐ Spinal conditions
- ☐ Fractures (if yes, please describe in the space below):

_____

_____

_____

RESPIRATORY
- ☐ Asthma
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Shortness of breath
- ☐ Other: _____

INFECTIONS/DISEASES
- ☐ AIDS/HIV
- ☐ Hepatitis
- ☐ Herpes
- ☐ Tuberculosis
- ☐ Influenza (flu)
- ☐ Other:_____

HEAD/NECK
- ☐ Concussion
- ☐ Traumatic brain injury
- ☐ Dizziness
- ☐ Fainting
- ☐ Nausea
- ☐ Headaches
- ☐ Migraines
- ☐ Whiplash injury
- ☐ Vertigo
- ☐ Double vision
- ☐ Blurry vision
- ☐ Vision loss (please circle if you wear the following):
  - Glasses/ contacts
- ☐ Glaucoma
- ☐ Hearing loss
- ☐ Ear conditions

FOR WOMEN:

Are you currently pregnant?
- ☐ Yes
  - # of weeks:_____
- ☐ No

OTHER
- ☐ Back pain
- ☐ Chest pain
- ☐ Depression
- ☐ Anxiety disorder
- ☐ Chronic fatigue
- ☐ Chronic pain
- ☐ Cancer
- ☐ Diabetes
- ☐ Hernia
- ☐ Jaundice
- ☐ Ulcers
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Thyroid disease
- ☐ Seizures/ convulsions
- ☐ Epilepsy
- ☐ Swelling of hands and feet
- ☐ Drug abuse
- ☐ Skin conditions
- ☐ Easily bruised

Please list any other medical conditions you may have not listed above:

_____

_____

List any surgeries you have had:

_____

_____

Do you have any metal/foreign objects implants (please circle)? **YES** (where:_____) **NO**

List any medications you are currently taking:

_____

_____

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Name:_____

List any allergies you have (seasonal, drug, food, material, etc.):

_____

_____

Do you have an EpiPen? **[ ] YES [ ] NO**

Any significant weight changes in the last year?

[ ] YES +_____lbs **-**_____lbs **[ ] NO**

Are you under the care of any other medical/ healthcare provider or physician? **[ ] YES [ ] NO**

If yes, please list type of provider(s) and name(s):

Please list your reason(s) for coming to Advance Physiotherapy Clinic:

_____

_____

Have you had any special testing regarding your current condition (CT scan, MRI, X-ray, etc.)?: **[ ] YES [ ] NO**

If yes, please list:

To the best of my knowledge, the information listed herein is correct. I understand that it is my responsibility to inform my therapist of any changes to my health that may arise in the future:

_____ _____

Client signature (parent/guardian if under 16 or substitute decision-maker) Date signed

Your privacy is of utmost importance to us. In order to communicate with your care team (which may include healthcare providers, physicians, case managers, insurers, lawyers, etc.) and release and/or obtain your medical documentation and records from/to your care team, we require your written consent. Your medical information is strictly confidential and kept securely in electronic and hardcopy format.

I, _____, give consent to Advance Physiotherapy Clinic to communicate with my care team and release/obtain my medical documentation and records from/to my care team in regards to my treatment and health. I understand that I may revoke this consent at any time by notifying Advance Physiotherapy Clinic:

_____ _____

Client signature (parent/guardian if under 16 or substitute decision-maker) Date signed

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CONSENT TO PHYSIOTHERAPY

I hereby request and consent to physiotherapy evaluation and treatment that falls under the scope of practice of the professionals treating me who are either employed by or contracted by Advance Physiotherapy Clinic.

I understand that physiotherapy may involve some undressing. I understand that at all times the therapist will abide by my wishes with regards to my comfort level of undress. I also understand that I can request an area not to be treated or exposed.

I have the right to decline treatment at any time. The therapist will explain your physiotherapy assessment findings and discuss treatment recommendations with you. 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 I have questions regarding treatment and services provided, I understand that I will speak to my therapist.

I understand that physiotherapy treatment may involve manual therapy, stretches, mobilization, strengthening exercises, cardiovascular training, and an individualized exercise program. Treatment may also include the application of topical pain relief gels/creams, therapeutic taping, heat, ice packs, electrical stimulation, laser and ultrasound. Depending on your condition, treatment may also include vestibular therapy and balance training. I understand that there may be potential risks associated with treatment. Potential risks include, but are not limited to, allergic reactions/skin rashes from topical creams, blistering, skin irritation, muscle soreness from stretches and resistance exercises, falls, dizziness, lightheadedness, loss of balance and/or an aggravation of symptoms. I understand that the risks are very minimal but may occur, and I will be able to discuss this and the nature of my treatment with my treatment provider. I will report immediately to my treatment provider if any side effects occur.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions regarding its content, and by signing below I agree to the above named procedures. I intend for this consent form to cover treatment for my present condition, as well as all future conditions for which I may seek treatment. I acknowledge I have the right to withdraw this consent at any time by notifying professionals who are treating me and who are either employed by or contracted by Advance Physiotherapy Clinic.

The Health Information Custodian at Advance Physiotherapy Clinic is Marek Siekanowicz, Registered Physiotherapist.

_____ _____

Client Name **Date**

_____

Client Signature (parent/guardian if under 16 or substitute decision-maker)

_____ _____

Health Information Custodian **Witness**

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THERAPY SERVICES FEE SCHEDULE

Thank you for choosing Advance Physiotherapy Clinic (APC) for your rehabilitation needs. Fees for physiotherapy and massage therapy services are based on guidelines developed by Ontario Physiotherapy Association (OPA), Registered Massage Therapy Association of Ontario (RMTAO), or Financial Services Commission of Ontario (FSCO).

Private Clients:

Physiotherapy Assessment & Treatment: $100.00-$120.00 per session
Physiotherapy Treatment (average 1 hour session): $80.00-$100.00 per session
Therapeutic Massage (30 min): $55.00 (HST included)
Therapeutic Massage (45 min): $82.50 (HST included)

For clients with Extended Health Care (EHC) benefits, we are able to submit claims online if your policy allows for it. Should payment not be made to APC after online submission, clients are responsible for paying the outstanding amount to the clinic. If your policy does not allow online submission, we can assist you with submitting the claim manually and/or provide a receipt for you to submit to your EHC provider. Clients are responsible for paying any outstanding amount, including the difference if EHC insurance does not cover 100% of the claim.

MVA (Motor Vehicle Accident) Clients:

Treatments recommended and approved will be charged according to Financial Services Commission of Ontario's (FSCO) recommended fee schedule for services rendered to clients. Should you have Extended Health Care (EHC) benefits, all invoices for accident related healthcare services must be first submitted to your EHC provider prior to consideration by the auto-insurer. Should payment not be made to APC after submission, clients are responsible for paying the clinic any amount that was paid to the member by their EHC benefits for the claim. This will later be deducted from the invoices sent to the auto-insurer.

Should you obtain EHC benefits in the future as an MVA client, you are responsible for notifying our office and disclosing this information.

I verify that I have read and understand the above and agree to the terms and conditions, and that all unpaid fees are my responsibility. In the event of non-payment by my insurer, I understand that I am personally responsible to Advance Physiotherapy Clinic for all fees incurred for my treatment(s).

Client Name: _____

Client Signature: _____

*** Acceptable methods of payment include:** cash, cheque, debit card, or credit card (Visa, American Express, Interac or MasterCard)

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CANCELLATION POLICY

If you need to cancel an appointment or reschedule we ask that you **email or call us as soon as possible.** Please provide 24 hours' notice unless in the event of an emergency. Your attention to this matter and consideration of the therapist's time keeps our clinic running smoothly and helps us provide our clients the best possible care. Thank you for understanding!

If you need to cancel or reschedule your appointment, **please remember to cancel your taxi/trans-help rides. We are not responsible** for scheduling or cancelling your transportation arrangements.

To ensure the safety of our patients and staff, the clinic will be closed on days with severe snow storm warnings and/or poor snow conditions.

I have read and understand the cancellation policy:

_____

Client Signature (parent/guardian if under 16 or substitute decision-maker)

OUR CONTACT INFORMATION:

Advance Physiotherapy Clinic
Phone: 905 792 7424
Email: appointments@advancephysiotherapyclinic.com