PURE FORM PHYSIOTHERAPY

Confidential Patient Intake Form

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided will be kept confidential unless allowed or required by law. Your written permission will be required to release any information outside this clinic.

Today's Date (M/D/Y):			
LAST NAME:	**FIRST NAME:**	**Date of Birth (M/D/Y):**	
Legal Guardian (if patient is under 18 years of age):			
Address:	**City:**	**Prov:**	**P.Code:**
Home #:	**Cell #:**	**Work #:**	
Email:_____ May we send you your appointment reminders and receipts via email? ☐ Yes ☐ No May we send you clinic notifications/updates via email? ☐ Yes ☐ No			☐ Male ☐ Female
Occupation:			
Family Physician's Name:	**City:**	**Phone #:**	
Emergency Contact:	**Relationship:**	**Phone #:**	

☐ **Motor Vehicle Accident Claim (ICBC)** - please tick and complete information below if this applies

Date of Accident:_____ PHN (Care Card#):_____

ICBC Claim#:_____ Adjuster Name:_____ Adjuster Ph#:_____

☐ **MSP Premium Assistance Coverage** - please tick and complete information below if this applies

PHN (Care Card#):_____

How did you hear about our office?

☐ Physician:_____ ☐ Family/Friend ☐ Website ☐ Live in the area

☐ Other:_____

PURE FORM PHYSIOTHERAPY – MEDICAL HISTORY

Please check ☑ conditions you are currently experiencing or have experienced in the past.

MUSCLES/JOINTS *Please indicate the right or left side where appropriate*

☐ Upper back	R L	☐ Wrist	R L	☐ Weakness/loss of strength		☐ Tendonitis	
☐ Mid back	R L	☐ Hand	R L	☐ Clumsiness		Location:_____	
☐ Lower back	R L	☐ Hip	R L	☐ Multiple Sclerosis		☐ Strain	
☐ Shoulders	R L	☐ Leg	R L	☐ Muscular Dystrophy		Location:_____	
☐ Elbows	R L	☐ Knee	R L	☐ Arthritis		☐ Joint sprain/dislocation	
☐ Arm	R L	☐ Ankle	R L	☐ Osteoarthritis		Location:_____	
☐ Neck	R L	☐ Foot	R L	☐ Rheumatoid arthritis		☐ Artificial joints/pins/wires/screws	
				☐ Orthotics		Location:_____	

SKIN

☐ Rashes/bruises easily
☐ Contagious skin conditions
☐ Skin allergies
☐ Infectious skin conditions
☐ Other:_____

HEAD/NECK

☐ Visual impairment
☐ Hearing impairment
☐ Hearing aid
☐ Speech impairment
☐ Sinus problems
☐ Jaw pain (TMJ pain)
☐ Headache/migraine

RESPIRATORY

☐ Asthma
☐ Bronchitis
☐ Chronic cough
☐ Emphysema
☐ Difficult breathing
☐ Shortness of breath
☐ Smoking
☐ Other:_____

CARDIOVASCULAR

☐ High / low blood pressure
☐ Bleeding disorder
☐ Hemophilia
☐ Arteriosclerosis
☐ Heart attack
☐ Angina
☐ Stroke / cerebrovascular accident
☐ Pacemaker / internal defibrillator
☐ Varicose Veins
☐ Phlebitis
☐ Poor circulation
☐ Other:_____

WOMEN

☐ Pregnant? Due Date:_____
No. of children:_____

INFECTIOUS CONDITIONS

☐ Herpes / STDs
☐ Hepatitis:_____
☐ HIV / AIDS
☐ Tuberculosis (TB)
☐ Other:_____

OTHER CONDITIONS

☐ Cancer
☐ Diabetes
☐ Fainting
☐ Insomnia
☐ Kidney problems
☐ Numbness / tingling
☐ Anxiety
☐ Depression
☐ Vestibular / balance problems
☐ Chronic pain
☐ Fibromyalgia
☐ Allergies:_____

PAST FRACTURES OR SURGERIES

☐ Fracture Date:_____
Location?_____
☐ Car Accident(s) Date(s):_____
_____
☐ Surgery Date:_____
For?_____
Date:_____
For?_____

MEDICATIONS

Please list all medications, natural remedies, supplements, etc.

CURRENT SYMPTOMS *(check all that apply)*

☐ Chest pain ☐ Headaches ☐ Coordination problems ☐ Visual problems
☐ Loss of balance ☐ Weakness ☐ Decreased range of motion ☐ Pain at night
☐ Hearing problems ☐ Difficulty sleeping ☐ Difficulty concentrating ☐ Vertigo / dizziness
☐ Other:_____
How long have you had the above symptoms?_____
What makes your symptoms worse?_____ Better?_____
On a scale of 1-10 (with 0 being no pain and 10 being the worst pain) how would you rate your pain? 0 1 2 3 4 5 6 7 8 9 10

OTHER

Sports & Activities:_____

PURE FORM PHYSIOTHERAPY

INFORMED CONSENT TO MASSAGE THERAPY TREATMENT and RELEASE OF INFORMATION

I, the undersigned, voluntarily consent to the registered massage therapists ("RMT") and Pure Form Physiotherapy (the "Clinic") providing massage therapy services (the "Treatment") to me, now and on an ongoing basis, with such Treatment to be within the scope of the RMT practice as defined by the College of Massage Therapist of British Columbia, including without limitation, such assessments, examinations and techniques, as recommended by the RMT. I consent to the RMT undraping areas of my body to the extent needed to provide Treatment while considering my comfort, security, and privacy as requested by me. I understand that at any time I may withdraw my consent to Treatment by informing the RMT with words to that effect, and then Treatment will be stopped. _____(Initial)

I agree that Treatment is not a substitute for a medical examination and diagnosis by a medical physician. I agree that no assurance or guarantee has been provided to me by RMT or the Clinic as to any results of Treatment. _____(Initial)

POSSIBLE RISKS ASSOCIATED WITH TREATMENT

I agree that my consent is given while informed of the fact that possible and likely risks to me exist during the course of Treatment, including, but not limited to, muscle strains and sprains, bruising, light headedness, dizziness and tenderness. I agree that the RMT is not able to explain unanticipated risks and complications and as such there may be other risks associated with Treatment in addition to those identified above.

_____(Initial)

DUTY TO DISCLOSE MEDICAL HISTORY

I agree that I have a duty to fully disclose to the RMT and Clinic all medical conditions affecting me, whether or not I believe any medical condition is applicable or relevant to my Treatment. I further agree that it is my responsibility to keep the RMT updated and informed of my medical condition. I declare that the information I have provided in the above Medical History Form is true, accurate and complete. _____ (Initial)

DISCLOSURE OF PERSONAL INFORMATION

I understand that it may be desirable from time to time for the RMT and Clinic to coordinate my health care with others, including but not limited to other Clinic staff, physicians, other health care providers, case managers, and insurance claim adjusters ("Other Providers"), which results in disclosing my personal information (as defined in the Personal Information Protection Act (the "Act"). I consent to the RMT and Clinic disclosing my personal information to Other Providers, when done in accordance with the Act. I consent to the shared access between the RMT and the Clinic staff to my personal information. I agree that I must expressly withdraw consent of the disclosure of my personal information by providing 2-business day notice of such withdrawal of consent in writing to the RMT and Clinic.

_____(Initial)

By signing below I agree that I have read and understood the above information and that I have had the opportunity to ask the RMT and Clinic any questions regarding the contents of my consent and my Treatment.

AGREEMENT TO FEES

I understand that I am solely responsible for paying the fee associated with each treatment session. I agree to pay this fee that is in accordance with the most current fee schedule at the time of each visit.

I understand that if my claim is to be submitted directly to an outside agency for payment, and for any reason the third party payer denies the claim and/or refuses to pay all or any of the full amount billed, I am fully and solely responsible for paying the outstanding amount.

CANCELLATION POLICY

I understand that in the event that I fail to provide **at least 8 business hours** of advanced notice to cancel my appointment a cancellation fee will be charged. This cancellation fee is in accordance with the most current fee schedule set for the RMT I was scheduled to see.

_____

Patient Name (please print)

_____ _____

Patient Signature (or Legal Guardian) **Signature of Witness**

_____

Date