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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 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:_________________________

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PURE FORM PHYSIOTHERAPY

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
☐ Mid back R L
☐ Lower back R L
☐ Shoulders R L
☐ Elbows R L
☐ Arm R L
☐ Neck R L

☐ Wrist R L
☐ Hand R L
☐ Hip R L
☐ Leg R L
☐ Knee R L
☐ Ankle R L
☐ Foot R L

☐ Weakness/loss of strength
☐ Clumsiness
☐ Multiple Sclerosis
☐ Muscular Dystrophy
☐ Arthritis
☐ Osteoarthritis
☐ Rheumatoid arthritis
☐ Orthotics

☐ Tendonitis
Location:____________________________
☐ Strain
Location:____________________________
☐ Joint sprain/dislocation
Location:____________________________
☐ Artificial joints/pins/wires/screws
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

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
☐ Loss of balance
☐ Hearing problems
☐ Headaches
☐ Weakness
☐ Difficulty sleeping
☐ Coordination problems
☐ Decreased range of motion
☐ Difficulty concentrating
☐ Visual problems
☐Pain at night
☐ 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:____

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PURE FORM PHYSIOTHERAPY

INFORMED CONSENT TO PHYSIOTHERAPY TREATMENT and RELEASE OF INFORMATION

I, the undersigned, voluntarily consent to the physiotherapists ("PT") and Pure Form Physiotherapy (the "Clinic") providing physiotherapy services (the "Treatment") to me, now and on an ongoing basis, with such Treatment to be within the scope of the PT practice as defined by the College of Physical Therapists of British Columbia, including without limitation, such assessments, examinations and techniques, as recommended by the PT. I consent to the PT 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 PT 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 PT 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 PT 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 PT 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 PT 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 PT 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 PT and Clinic disclosing my personal information to Other Providers, when done in accordance with the Act. I consent to the shared access between the PT 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 PT 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 PT 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 PT I was scheduled to see.

____

Patient Name (please print)

____

Patient Signature (or Legal Guardian)

____

Signature of Witness

____

Date

PURE FORM PHYSIOTHERAPY

DRY NEEDLING, GUNNIMS & ACUPUNCTURE INFORMATION AND CONSENT

Dry needling and/or GunnIMS is helpful for reducing shortened bands of muscle and for restoring normal tone to muscles thus improving mobility of your joints. Acupuncture is used to help with certain pain syndromes. All three treatments use a fine acupuncture needle that is inserted either into the trigger point of a muscle to facilitate its release or into a specific acupuncture point. You may experience a muscle twitch and/or deep muscular ache when the needle is inserted into the muscle; this is a normal response to this technique.

Dry needling, GunnIMS and Acupuncture are valuable treatments for musculoskeletal problems but like any medical procedure, there are possible complications. While these complications are rare in occurrence, they need to be considered prior to giving consent to the procedure.

POSSIBLE RISKS ASSOCIATED WITH TREATMENT

- **Dry needling and/or GunnIMS may cause post treatment soreness lasting one to two days, followed by an improvement in the overall pain state. If you experience significant post-treatment soreness, topical application of heat is recommended and gentle range of motion of the sore area.**
- **A needle may be placed inadvertently in a capillary or vein, which will subsequently cause a small painless bruise. Your therapist will notify you should this occur during your treatment.**
- **Any time a needle is used there is a risk of infection. To reduce this risk we clean the area with stanhexadine and use sterile disposable acupuncture needles. Please contact your physiotherapist if anything that may seem like an infection occurs.**
- **When a needle is inserted near the chest wall there is a rare possibility of it creating a pneumothorax (air in the chest cavity). This complication is not fatal and is readily reversible. We reduce the risk by only inserting the needle over bony points and/or lifting the muscle away from the chest surface and inserting the needle parallel to the chest.**

Patients are required to inform their physiotherapist if they are pregnant, use blood thinners, have been exposed to blood diseases such as Hepatitis or HIV, or have any conditions that increase bleeding prior to treatment. In addition, all surgeries should be reported.

I have read the above and agree that I understand the risks involved with Dry Needling, GunnIMS and Acupuncture.

_______________ (Initial) ←

I consent to examination/treatment using Dry Needling, GunnIMS and Acupuncture at Pure Form Physiotherapy.

_______________ (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 PT and Clinic any questions regarding the contents of my consent and my Treatment.

____

Patient Name (please print)

____

Patient Signature (or Legal Guardian)

____

Signature of Witness

____

Date