Richview Physiotherapy & Rehabilitation Centre Inc
Patient Intake Form
3 Pages

Last Name	First Name	
Home Address		
City	Province	Postal Code
Home Phone	Cell Phone	Work Phone
Date of Birth	Date of injury	Email:

Release of Information

I, _____give Richview Physiotherapy & Rehabilitation Centre my consent to release / obtain / share information from the my physician with respect of my care:

Physician (s)_____ Initials:_____

Direct Referral By: Doctor_____ Friend_____ Advertisement_____ Other_____

Consent for Assessment and Treatment

Physiotherapy treatment techniques may include, but are not limited to: manual techniques (mobilization, manipulation), electrotherapeutic modalities, acupuncture and exercises etc. These may be recommended during your program. There is also an inherent risk of aggravation and discomfort during the treatment session. It is the policy of Richview Physiotherapy & Rehabilitation Centre to ensure that the benefits, side effects, and potential complications of each chosen modality above are explained to you by your therapist. Throughout the program, should you have questions or concerns about any treatment, you must inform the therapist immediately so rationale treatment and/or adjustments to your plan of care can be made. It is your responsibility to participate in all aspects of the program as it is imperative to it is success. If you choose not to participate, you must inform your therapist immediately.

I understand and agree with the above policy. I agree to participate in an assessment and treatment program delineated by Richview Physiotherapy & Rehabilitation Centre. I understand that I can withdraw my consent at any time.

_____ _____
Signature (if under 16, guardian must sign) Date

_____ _____
Witness Date

Respiratory:	**Soft Tissue/Joint Discomfort**	**Head and Neck**
☐ Chronic cough ☐ Shortness breath ☐ Bronchitis ☐ Asthma ☐ Emphysema **Infections**: ☐ Hepatitis ☐ TB ☐ HIV/AIDS ☐ Skin ☐ Other **Other Concern**: ☐ Loss of Sensation ☐ Numbness/Tingling ☐ Dizziness/Fainting ☐ Pain with no history of injury ☐ Severe Spasm ☐ Difficulty Speaking or Swallowing ☐ Recent Nausea or Vomiting ☐ Unexplained Fatigue ☐ High Blood pressure ☐ Low Blood Pressure ☐ Muscular Dystrophy ☐ Pacemaker	☐ Neck ☐ Low Back ☐ Mid Back ☐ Upper Back ☐ Shoulders ☐ Elbows ☐ wrist/Hands ☐ Arms ☐ Hips ☐ Knees ☐ Ankles/Feet ☐ Legs ☐ Muscle Cramping ☐ Jaw ☐ Weakness or Paralysis _____ ☐ Other: _____	☐ Vision problems ☐ Ear problems (fullness, ringing, loss) ☐ Head trauma ☐ Headache / Migraines ☐ Sinus Problems ☐ Past Whiplash Injury

Medication
List of any medications taken for this problem or for other medical conditions:

_____
_____
_____

Treatment and Testing

Physical Therapy ☐ Yes ☐No When: _____ Where: _____
X-Rays ☐ Yes ☐No When: _____ Where: _____
MRI / CT Scan ☐ Yes ☐No When:_____ Where: _____

Emergency Contact

Name:_____ Phone#:_____ Other #:_____

Relation:_____

Payment information

I understand that payment for services at Richview Physiotherapy & Rehabilitation Centre is my responsibility. If my claim is to be submitted to an outside agency for payment, and for any reason the third party payer, such as insurance or employer, pays partial, denies and/or refuses to pay for the full amount I will be billed; I am responsible for payment. I understand the fee per visit/sessions are:

Fee: Assessment $_____90_____ Treatment$_____65____ ***INITIALS:_____***

Visa / MasterCard #_____ Exp date_____

Extended Health Benefits Information Primary

Company Name:_____

Member Relation (circle one): Self Spouse Child

Member Name: _____ Member DOB: ___/___/_____
dd mm yyyy

Plan/Policy #:_____ ID/Certificate #:_____

Extended Health Benefits Information Secondary

Company Name:_____

Member Relation (circle one): Self Spouse Child

Member Name: _____ Member DOB: ___/___/_____
dd mm yyyy

Plan/Policy #:_____ ID/Certificate #:_____

CANCELLATION POLICY:

PLEASE NOTIFY THE CLINIC 24 HRS IN ADVANCE FOR ANY CANCELLATION OR A $50.00 CHARGE WILL BE A Informed Consent to Physiotherapy Treatment

Informed Consent to Physiotherapy Treatment

Physiotherapy is a primary care, autonomous, client-focused health profession dedicated to

- Improving and maintaining functional independence and physical performance,
- Preventing and managing pain, physical impairments, disabilities and limits to participation;
- and promoting fitness, health and wellness.

Physiotherapists provide assessment, treatment and education for a wide range of health problems to ensure you make the most of your lifestyle.

Physiotherapy involves using a variety of techniques to help your muscles, joints, heart and lungs work to their potential. Physiotherapists work in partnership with individuals of all ages to break down barriers impending physical function. Physiotherapy can help individuals living with congenital or chronic diseases or other debilitating conditions and can assist those recovering from surgery; illness; neurological conditions such as stroke; injury; industrial or motor vehicle accidents; or age related conditions. The practice of physiotherapy is a drug-free.

Physiotherapists work with you to integrate your care into your lifestyle. They are skilled in providing treatment, preventative advice, rehabilitation and care for people with long-term or terminal illness and will develop a full treatment plan to suit your unique needs.

Physiotherapists are university educated, regulated health professionals. To ensure physiotherapist across the country apply consistently high standards, the Canadian Physiotherapy Association, the Alliance of Physiotherapy Regulators and the physiotherapy colleges of each province regulate the practice of physiotherapists in the public interest.

I acknowledge I have discussed, or have had the opportunity to discuss with my physiotherapist, the nature and purpose of my treatments, and are agree to the treatments offered and recommended. I intend this consent to apply to all my present and future physiotherapy care.

Date_____ Patient Signature:_____

Patient's Name (please print):_____

Physiotherapist's signature:_____