1201 Britannia Road W, Unit # 7C, Mississauga ON L5V 1N2
info@realignphysio.ca Tel: +1647 945 7561 Fax: 647 499 7521

Initial Intake Form

Have you ever been a patient here before? ☐ Yes ☐ No If Yes, date of last visit: _____

How did you learn about us? If referred, please mention the name: _____

Patient Name: _____ DOB: _____

Address: _____ Apt/Unit #: _____

City/Town: _____ Province: _____ Postal Code: _____

Home # _____ Cell # _____ Work # _____

Email Id: _____

How would you like us to contact you: ☐ Text msg ☐ Phone ☐ Email

Emergency Contact: Name: _____ Contact No: _____

Party responsible for Payment: _____

Workplace: _____

Address: _____ Postal Code: _____

Extended Health Coverage Insurance Company:

Group # _____ ID# _____ Phone # _____

Policy Holder Name: _____ DOB: _____

Relationship to Member: _____ Policy Holder Workplace: _____

MVA: Insurance Company: _____ Date of loss: _____

Claim #: _____ Adjuster name: _____

Address: _____

Fax: _____ Phone no: _____

WSIB claim #: _____ Date of Accident: _____

Case Manager: _____

The information requested below will assist us in treating you safely. Feel free to ask us 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 consent will be required to release any information.

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Have you travelled outside Canada in last 4 weeks? □ Yes □ No If yes, where? _____

Are you experiencing Flu like Symptoms such as cough, fever, shortness of breath? □ Yes □ No

If yes, have you consulted your physician? □ Yes □ No

Have you received treatment from: □ RMT □ Physiotherapist □ Chiropractor □ Other _____

Please list any current medications and the conditions they are treating: _____

Please list any major injuries, accidents, surgeries (approx. date): _____

Do you have any previous experience with Massage Therapy? □ Yes □ No

If yes, last date of massage therapy treatment: _____

Primary complaint, cause and location of discomfort: _____

When did the pain/discomfort start? _____

Did the current injury result from MVA/ workplace injury: □ Yes □ No

Have you had any of the following regarding your current condition?

□ Physical examination □ X-ray □ Other diagnostic test

How often do you feel pain/discomfort? □ Constant □ Comes & goes suddenly

□ Comes & goes gradually □ Other _____

Nature of pain/discomfort feel: □ Sharp □ Aching □ Throbbing □ Burning □ Tight □ Other___

Pain/discomfort is brought on/made worse by: □ Sitting □ Standing □ Lifting □ Bending

□ Exercise/Physical Activity □ Other _____

Pain intensity: □ Mild □ Moderate □ Severe

Pain/discomfort feels better with: □ Ice □ Heat □ Anti-inflammatory medication

□ Rest □Activity

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Health History Questionnaire:

Head/Neck: □ Whiplash □ Headaches/Migraines □ Concussion □ Ringing in Ears
□ Hearing Loss □ Vision Problems □ Brain Injury □ Sinus Pain □ Other

Respiratory: □ Asthma □ Shortness of Breath □ Chronic Cough □ Bronchitis □Emphysema
□ Sinusitis □ Frequent Colds □ Pneumonia □ Tuberculosis □ Smoker □Other

Cardiovascular: □ High Blood Pressure □ Low Blood Pressure □ Heart Attack □ Stroke
□ Angina / Chest Pain □ Chronic Congestive Heart Failure □ heart disease
□ Poor Circulation □ Phlebitis / Varicose Veins □ Pacemaker □ Hemophilia
□ Family History of Cardiovascular Problems □ Other

Digestive: □ Constipation □ Diarrhea □ Crohn's / Colitis □ Nausea □ Diverticulitis
□ Ulcers □ Other

Nervous System: □ Sensory Loss / Change □ Numbness / Tingling □ Spinal Cord Injury
□ Thoracic Outlet Syndrome □ Carpal Tunnel Syndrome □ Sciatica
□ Epilepsy □ Seizures □ Cerebral Palsy □ Parkinson's
□ Multiple Sclerosis □ Other

Musculoskeletal System: □ Sprain/ Strain □ Dislocation □ Arthritis □ Tendonitis □ Bursitis
□ Fractures □ Plantar Fasciitis □ Postural Deviation
□ Degenerative Disc Disease □ Pins / Plates / Wires / Artificial Joint
□ Family History of Arthritis □ Other

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Muscle/Joint Pain: ☐ Jaw ☐ Neck ☐ Upper Back ☐ Middle Back ☐ Lower Back ☐ Shoulder ☐ Arm ☐ Elbow ☐ Wrist ☐ Hand ☐ Hip ☐ Leg ☐ Knee ☐ Ankle ☐ Feet ☐ Other

Skin/Infections: ☐ Infectious Skin Conditions ☐ Bruise Easily ☐ Hives ☐ Acne ☐ Allergies / Hypersensitivity ☐ Dermatitis / Eczema ☐ Burns ☐ Open Wound / Lesion ☐ Hepatitis ☐ HIV / AIDS ☐ Other

Other Conditions: ☐ Cancer ☐ Diabetes ☐ Fibromyalgia ☐ chronic fatigue syndrome ☐ Psychiatric Disorder ☐ Other

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify my therapist of any changes to my health or personal information.

Patient/ guardian Signature: Date:

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CONSENT AND POLICIES

Please read the following carefully

REALIGN PHYSIO & WELLNESS CENTER is a multidisciplinary health care provider where the practitioners work in conjunction to provide you, the patient, thorough care and treatment. All staff members are required to sign a confidentiality form with regards to your personal information and are trained in appropriate use and protection of your information. We will use your information to coordinate your treatment, to communicate with your physician (with your written consent) regarding your status in physiotherapy, to conduct internal audits and quality of care reviews. We also provide information when required by law.

All handling of your information is compliant with existing college guidelines and provincial and federal legislation. Our clinic uses your information to ensure you receive the best care. Please review the intake paperwork you were asked to complete prior to your first visit. If you have any questions, please do not hesitate to speak with your therapist.

I give REALIGN PHYSIO & WELLNESS CENTER, my consent to release / obtain information from the following individuals with respect to*

☐ Physician(s)

☐ Insurer/ Lawyer

☐ Family Member

☐ Employer

☐ WSIB

☐ Other

☐ None of the above / not applicable

E-MAIL

☐ I give permission for Realign Physio & Wellness Center to use the email provided to send reminder emails of scheduled appointments, for paperless billing and for information regarding changes in clinics offerings.

You have the right to:

- receive courteous professional service
- ask for clarification on your treatment plan and questions pertaining to your care
- review or obtain a copy of your personal health information
- request that we complete information or correct any inaccurate information in your record
- request a list of individuals we release medical information to
- request in writing that specific person(s)/agency(ies) not receive specific information

We ask that you:

- try to keep your appointments, and to call as soon as possible if you must cancel or reschedule any appointment
- keep us aware of any changes in your condition, insurance coverage or other medical appointments
- respect the privacy of others
- respect others in our clinic both verbally and non-verbally

PAYMENT INFORMATION*

 I understand that payments for services at REALIGN PHYSIO & WELLNESS CENTER are my responsibility after every service is received. 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 denies and/or refuses to pay for the full amount I am billed, I am responsible for payment.

CLINIC POLICIES AND CONSENT*

In order to serve our clients promptly and professionally, we need to adhere to a precise schedule. To achieve this, we ask that our clients arrive on time for their appointments, and when necessary, provide ample notice for cancellations. Please understand and adhere to the following clinic policies. When you book an appointment, that time is set aside for you, and missed appointments prevent us from accommodating other clients. Please understand that therapists only get paid when they deliver a service.

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ARRIVING LATE*

If you arrive late, your treatment may be shortened in order to accommodate other clients whose appointments follows yours. Depending upon how late you arrive, your therapist will then determine if there is enough time remaining to start a treatment. Regardless of the length of the treatment given, you will be responsible to pay for the full session; however, we will do our best to satisfy the scheduled time.

CANCELLATION OF APPOINTMENT*

I understand that REALIGN PHYSIO & WELNESS CENTER requires a minimum of 24 hours notice for any appointment cancellations. Should you give less than 24 hours notice, a $25.00 cancellation charge may be charged. Future appointments will be denied until payment is made.

NO SHOW*

Your appointment time has been reserved specifically for you. Should you book an appointment and not to attend, you are responsible to pay for the entire cost of the appointment, before having any other treatments done

Please note that extended health coverage does not reimburse for missed appointment fees. If you are a WSIB or MVA client and your claim is denied, you are responsible for payment of all treatments rendered.

If an emergency arises, please let us know so that we can treat your specific situation with personal attention. We recognize that there are circumstances that are out of your control (sudden illness, family emergencies, etc.) and your therapist may make an exception to the above policies on those rare occasions.

If making your regularly scheduled appointments is difficult for you for any reason, please let us know and accommodations may be made. Ultimately, your care is the most important thing to us, and being able to attend your full treatment sessions as scheduled is necessary to get the best results in a timely manner.

REALIGN PHYSIO & WELLNESS CENTER may change its policies at anytime without notice. The latest policy will be posted.

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RENDERING OF EVALUATIONS, TREATMENTS AND/OR SERVICES*

 I hereby consent to the rendering of evaluations, treatments and/or services as communicated by the RMT named below. My consent is voluntary, and I intend this consent to cover the entire course of assessment/treatment commencing on the date indicated below. I understand that I may ask questions at any time regarding the assessment and treatment and that this consent may be withdrawn at any time.

We strive to ensure your time with us is productive and enjoyable, and you are always welcome to call us with questions, to give us feedback or to pass along compliments. You are welcome to contact us at any time.

Thank you for your cooperation.

Patient/Guardian Name:

Signature:

Date:

Reg. Massage Therapist:

Signature:

Date: