MOVE PHYSIOTHERAPY

movephysio.ca
(902) 832-6699
1181 Larry Uteck Blvd. Suite 103

Personal Information

Name (First, Middle, Last): ______________________________

How did you hear about us? ______________________________

Mailing Address: ______________________________

______________________________ Postal Code: ______________

Phone - Home: ______________ Cell: ______________ Work: ______________

Email Address: ______________________________

Birthdate (Day/Month/Year): ______________ Health Card #: ______________

Occupation: ______________________ Gender: __________ Age: ______

Emergency Contact: ______________ Phone: ______________ Relation: ______________

Reason for Appointment Today: ______________________________

Is this related to:

Car Accident? ☐No ☐Yes Work Injury? ☐ No ☐ Yes

Consent for Release of Information

I, ______________________ , authorize MOVE Physiotherapy to use my mailing address, phone number and email address for appointment reminders and treatment follow up.

I, ______________________ , authorize MOVE Physiotherapy to use and disclose my medical information for purposes of treatment, payment and health care to the following:

- ☐ Family Physician: ______________________________
- ☐ Personal Healthcare Insurer: ______________________________
  Policy #: ______________ Member/ID #: ______________
  Policy Holder Name: ______________ Date of Birth: ______________
- ☐ Motor Vehicle Insurance Provider
- ☐ Worker's Compensation Board

I understand that I have the right to revoke this consent provided that I do so in writing, except to the extent that MOVE Physiotherapy has already disclosed the information based on this consent.

Health History

Are you presently being treated for any health conditions?

☐ No ☐ Yes (if yes please list) ______________________________

Are you presently taking any medications/vitamins/supplements?

☐ No ☐ Yes (if yes please list) ______________________________

____

Are you currently Pregnant ? ☐ No ☐ Yes - Due date: ______________________

Are you or were you ever a smoker ? ☐ No ☐ Yes

Please list previous injury and/or surgeries: ______________________________

____

Have you been to physiotherapy in the past ? ☐ No ☐ Yes

Can you perform daily home/work activities ? ☐ All ☐ Some ☐ With help ☐ Not at all

What is your current level of pain? (please circle one number)

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(no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain ever)

Please Check any that Apply (Past or Present):

☐ High or Low Blood Pressure
☐ Heart Condition:________________
☐ Stroke/CVA date(s): ________________
☐ Pacemaker (year of insertion) __________
☐ Swelling/Edema (Cause if known)
____
☐ Phlebitis/Varicose Veins/Bloot Clot
☐ Cancer (please list type and dates)
____
☐ Diabetes (please list type) ______________
☐ Osteoporosis (year of diagnosis) _________
☐ Fibromyalgia (year of diagnosis) ________
☐ Hepatitis (list type) _________________
☐ Epilepsy - Is it controlled: ☐ Yes ☐ No - Date of Last Seizure: _____________

☐ HIV/AIDS
☐ Skin Condition: ____________________
☐ Bowel/Bladder/GI Issues (please specify)
____
☐ Numbness/Tingling/Paralysis
☐ Respiratory Issues (please specify)
____
☐ Headaches/Migraines
☐ Allergies (please list) _________________
____
☐ Presence of internal pins, plates, screws or artificial joints (please list) ______________
____

Are you currently immunocompromised?
☐ Yes ☐ No

Please list anything else that your therapist should be aware of: ________________________
____

Cancellation/Late Policy

If you are unable to attend your scheduled appointment you are responsible for cancelling that appointment with **24 hours notice**. If you fail to do so, you MAY be charged a **25$ fee**. If calling outside of business hours, please leave a detailed message. If you arrive **15 minutes or more** past your scheduled appointment time you may be asked to **reschedule** and you MAY be charged a **25$ fee**.

Payment Agreement:

MSI does not cover any of our services; therefore you, the client, are responsible for payment of services rendered. Payment is due at the time of your appointment. Many clients have private health benefits to offset the cost of our services. We direct bill Blue Cross and all Companies part of Teuls Health. Worker's Compensation Board and Motor Vehicle Insurers. It is your responsibility to know the details of your plan. If you are covered under more than one policy, please note that we will only bill the primary policy. Any fees above this amount are your responsibility. (MOVE Physiotherapy reserves the right to refuse direct billing to any insurance company).

Please Note: If your claim is refused or denied by Worker's Compensation Board, your Motor Vehicle Insurer or your personal Healthcare Insurer, you are responsible for all payments for services rendered. These fees may include, but are not limited to the following: treatment fees, product fees and fees for any forms completed during treatment

Signature Client or parent/guardian: ____________________________ Date: ________________

Signature Witness: ____ Date: _________________