**PHYSIOTHERAPY PATIENT INFORMATION SHEET**

**PLEASE COMPLETE FULLY AND ACCURATELY**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal code: \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_

# Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ AHC #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency contact** (**Name, Tel. # & Relationship**): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail address (for appointment reminders): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How were you referred to this clinic?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Are your injuries related to a **Motor Vehicle Accident**?  N  Y If yes, date of accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FEMALES: Are you pregnant?  N  Y If yes, how many weeks? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please note that Megan Ewanowich does not accept WCB (Worker’s Compensation Board) Cases***

## CURRENT HEALTH HISTORY

**Current complaint(s)** – in order of importance to you: **On the drawings below, circle all painful areas:**

1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Describe the pain:**

  Sharp & stabbing  Burning

  Pins & needles  Dull, ache

  Numb  Stiff & tight

 Circle your level of **Pain/discomfort**

List any **medications, supplements** (vitamins, etc.) that you are currently taking:

|  |  |  |
| --- | --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

## FAMILY HEALTH HISTORY

Have you or anyone in your family had the following (**specify whom**):

 Heart disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High blood pressure \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## PAST HEALTH HISTORY

List any previous **Surgeries** and the year(s) they occurred:

**1**.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_\_\_ **3**.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_\_

**2**.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_\_\_ **4**.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_\_

 List any previous **Fractures/Breaks** and the year(s) they occurred:

**1**.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_\_\_ **3**.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_\_

**2**.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_\_\_ **4**.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year \_\_\_\_\_\_\_\_\_\_\_

## GENERAL HEALTH INFORMATION

Please check symptoms you have experienced in the past or currently:

|  |  |
| --- | --- |
|  Seizures/Stroke  Bleeding Problems  Chest Pain/Angina  |  Difficulty Speaking/Swallowing |
|  Osteoporosis  Anemia  High Blood Pressure  |  Recent Fall (last 6 months)  |
|  Osteoarthritis  HIV/AIDS/Hepatitis  Dizziness/Fainting Spells  |  Pacemaker/ICD  |
|  Rheumatoid Arthritis  Respiratory Condition  Hearing Loss/Change  |  Nausea/Vomiting  |
|  Headaches  Chronic Pain  Memory Loss/Change  |  Changes in Bladder Function  |
|  Tobacco/Cannabis use  Depression  Vision Loss/Change  |  Changes in Bowel Function  |
|  Poor Balance  Numb/Tingling  Fever/Chills/Sweats  |  Unexplained Weight Loss  |
|  Increased Pain at night  Recent Hospitalization  Skin Condition/Open Wounds  Metal Implants/IUD  |

## FEES

|  |  |
| --- | --- |
|  **Type of appointment**  | **Fee**  |
| Initial visit  | $115.00  |
| Subsequent Visit  | $75.00  |

**Do you have extended health benefits?**  YES  NO Benefits Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check at the front desk if your Insurance Provider is eligible for direct billing. For direct billing, **claims are submitted under PHYSIOTHERAPY**. We are submitting the claim on your behalf and your Insurance Provider predetermines approval. If your claim is rejected, not covered or processed as pending, **you are responsible for payment on your service at the time it is rendered.**

 If you cannot attend an appointment, or no longer need it, please give **2 HOURS NOTICE** so that another patient may receive care during that time. Please be courteous to other patients who are in need of an appointment. Failure to do so will result in a $40.00 fee. Understand that when you book an appointment, that time is set aside specifically for you and reserved. We are often booked back to back so arriving late (**10-15 minute maximum**), will be cut into your appointment time, and we will only be able to give you the remaining time in your session. In these cases, the full session fee will apply. (More than 15 minutes will be considered a missed appointment and will have to be rescheduled.)

**I have read the above and understand that I am responsible for all charges relating to my visit. The statements made on this form are accurate, to the best of my recollection, and I agree to allow this office to examine me for further evaluation.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT FOR TREATMENT**

* I understand that the health information collected is confidential in nature and will not be released without my prior written consent.
* I hereby consent to and authorize Megan Ewanowich, Licensed Physical Therapist, to perform therapeutic assessment and treatment.
* I understand that I can ask questions at any time, to clarify information and instructions provided by the therapist.
* I understand that I can withdraw my consent for participation at any time.
* I understand that the nature, purpose, and probable risks & benefits of all proposed treatments will be reviewed with me, including:

|  |  |
| --- | --- |
| **Acupuncture Therapy**  | **Exercise Therapy**  |
| Minor Bleeding/Bruising  | Muscle/Joint Soreness  |
| Infection  | Dizziness  |
| Fainting  | Risk of Falls  |
| Nerve/Tissue Injury  | Aggravation of Symptoms  |

* I confirm that I have informed the therapist of all pre-existing medical conditions that may impact my treatment,

including: pregnancy, presence of a pacemaker or metal implants, history of seizures, & the use of blood thinners.

**Acknowledgement:**

I acknowledge that I have read and understood this Agreement, that I appreciate and accept the risks associated with treatment and that I have executed this Agreement voluntarily.

Client’s name: (Please Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Practitioner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
|  | \*\*FOR PRACTITIONER USE\*\*  |  |
| **Problems/Concerns/Physical Diagnosis:**  | **Treatment Goals:**  | **Treatment Plan:**  |
|   |   |   |
|   |   |   |
|   |   |   |
|   |   |   |