PATIENT INTAKE FORM

KEY PHYSIOTHERAPY & REHABILITATION CENTRE

PERSONAL INFORMATION

First Name: _____ Last Name: _____ Date of Birth: *dd/mm/yy* _____

Email Address: _____

I agree to receive Email appointment reminders and understand I may opt out at any time: ☐ YES ☐ NO

Provincial Health Card #: _____

Preferred Phone #: _____ Is This a Mobile Phone?: ☐ YES ☐ NO

I agree to receive appointment reminders by text and I understand I may opt out at any time: ☐ YES ☐ NO

Street Address: _____ City: _____ Province: ____ Postal Code: _____

Area of Injury / Diagnosis: _____ Date of Injury / Start of Symptoms: *dd/mm/yyy* _____

Family Physician: _____ Referring Physician: _____

Emergency Contact Name: _____ Emergency Contact Phone #: _____

PRIVATE HEALTH INSURANCE INFORMATION

Private Physiotherapy and rehabilitation services are not covered through Provincial Health Care Coverage (aka: MSI). Therefore, we are required to administer charges directly to our patients and/or their health insurance provider for all our services If you have health coverage through a private insurance provider (we can submit invoices to them for your treatment costs. With a few exceptions we are able to directly bill your insurance provider online for these services

Insurance Company: _____

Policy Holder Name: _____ Policy Holder Date of Birth: *dd/mm/yyyy* _____

Plan #: _____ Policy #: _____ Plan #: _____

ID / Certificate / Subscriber #: _____

Percentage Covered: _____% Up to a Maximum of: $_____

☐ By checking this box I agree that I am responsible to pay any outstanding balance on my account, including co-payments, after each treatment session.

HEALTH INFORMATION

Please answer the following questions:

1. Do you have high blood pressure? ☐ YES ☐ NO
2. Do you have bowel or bladder problems? ☐ YES ☐ NO
3. Do you ever feel faint or have spells of severe dizziness? ☐ YES ☐ NO
4. Have you ever had a seizure? ☐ YES ☐ NO
5. Have you ever been diagnosed with cancer? ☐ YES ☐ NO
6. Do you have current fatigue or nausea? ☐ YES ☐ NO
7. Do you have diabetes? ☐ YES ☐ NO
8. Do you have asthma, emphysema or COPD ☐ YES ☐ NO
9. Do you have problems with circulation? ☐ YES ☐ NO
10. Do you have a pacemaker? ☐ YES ☐ NO
11. Do you have metal pins or plates inserted into bone? ☐ YES ☐ NO
12. Do you have problems with swelling in your legs or feet? ☐ YES ☐ NO
13. If female, are you pregnant? ☐ YES ☐ NO
14. Do you have any allergies? ☐ YES ☐ NO
    Please specify: _____
15. Do you have any other medical conditions not listed? ☐ YES ☐ NO
    Please specify: _____

Please list all of the prescribed AND over-the-counter medications you are currently taking:

Medication - Prescribed	Dosage	Frequency

Medication – Over the Counter	Dosage	Frequency

RESPONSIBILITY FOR PAYMENT OF SERVICES

I acknowledge that I am fully responsible for payment of services. Should my private health insurance carrier not cover the anticipated treatment costs or if there is a deductible to be paid prior to coverage commencing I understand that I am liable for the cost of any unpaid services. I also understand that KEY Physiotherapy & Rehabilitation Centre reserves the right to decline services should payment issues arise.

_____***Initials***

CONSENT TO COLLECT & RELEASE INFORMATION

KEY Physiotherapy & Rehabilitation Centre collects personal/personal health information solely for the purpose of providing you with quality care and service, including assessment, treatment and payment of services. This consent will remain in effect for twelve (12) months though you may withdraw consent at any time

I consent to the collection and use of my personal/personal health information by KEY Physiotherapy & Rehabilitation Centre. I understand that there are risks and benefits associated with providing this consent.

I consent to KEY Physiotherapy & Rehabilitation Centre contacting the individuals/organizations below to send copies of reports indicating my progress, to communicate with them as necessary regarding my care, as well to request information that may assist with my care.

_____	_____
Physician	WCB / Case Manager
_____	_____
Insurance Adjuster	Employer
_____	_____
Lawyer	Other

My consent is indicated by my signature below, and I understand that I may withdraw my consent at any time, effective upon the date of the request;

	dd/mm/yyyy
_____	_____
Client/Guardian Signature	Date
	dd/mm/yyyy
_____	_____
Witness Signature	Date