NOVO HEALTHNET LIMITED

PHYSIOTHERAPY INTAKE FORM – CLIENT PERSONAL INFORMATION (PLEASE PRINT)

PAYMENT FOR SERVICES IS DUE AT THE TIME OF YOUR APPOINTMENT

LAST NAME:	**FIRST:**	**DOB:**
STREET ADDRESS:	**CITY:**	**POSTAL CODE:**
PRIMARY PH NUMBER:	**ALTERNATE PH NUMBER:**	**EMERGENCY NAME & PH NUMBER:**
FAMILY DOCTOR:	**ADDRESS:**	

CHOSE CLINIC BECAUSE/REFERRED TO CLINIC BY? (please tell us how you heard of back on track)

EMAIL ADDRESS: (Your email address will only be used by our clinic to communicate with you. It will not be sold or distributed)

PLEASE CHECK CURRENT AND PREVIOUS CONDITIONS & WRITE THE APPROXIMATE DATE BESIDE

MUSKOSKELETAL CONDITIONS

_____OSTEOPOROSIS

_____OSTEOARTHRITIS

_____METAL IMPLANTS

_____PREVIOUS MOTOR VEHICLE ACCIDENTS

_____TMJ / DENTAL APPLIANCES / DENTURES

_____OTHER _____

_____NONE OF THE ABOVE

CARDIOVASCULAR CONDITIONS

_____ANGINA / HEART ATTACK

_____HIGH / LOW BLOOD PRESSURE

_____CIRCULATION PROBLEMS

_____ANAMIA / BLEEDING DISORDERS

_____PACEMAKER

_____OTHER _____

_____NONE OF THE ABOVE

NEUROLOGICAL CONDITIONS

_____STROKE _____PARKINSON'S

_____SEIZURES _____CONCUSSIONS

_____MULTIPLE SCLEROSIS

_____OTHER _____

_____NONE OF THE ABOVE

SYSTEMIC / OTHER

_____PREVIOUS SURGERIES _____DIZZINESS / FAINTING

_____ASTHMA _____PREGNANCY

_____EMPHYSEMA _____RINGING IN EARS

_____TUBERCULOSIS _____SWALLOWING PROBLEMS

_____THYROID PROBLEMS _____RECENT WEIGHT CHANGES

_____RHEUMATOID ARTHRITIS _____VISION / HEARING PROBLEMS

_____TUMOUR / MALIGNANCY _____ULCER

_____NERVOUS DISORDERS _____CIRCULATION PROBLEMS

_____KIDNEY /BLADDER /BOWEL PROBLEMS _____HERNIA

_____TRANSMITTABLE DISEASES _____

_____NONE OF THE ABOVE

PLEASE LIST ANY MEDICATIONS OR ANY OTHER CONDITIONS YOU WOULD LIKE KNOWN:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE. BY SIGNING BELOW I HAVE READ AND UNDERSTAND THE PAYMENT AND CANCELATION POLICIES

PRINT NAME OF GUARDIAN IF PATIENT IS UNDER 16: **RELATIONSHIP TO PATIENT:**

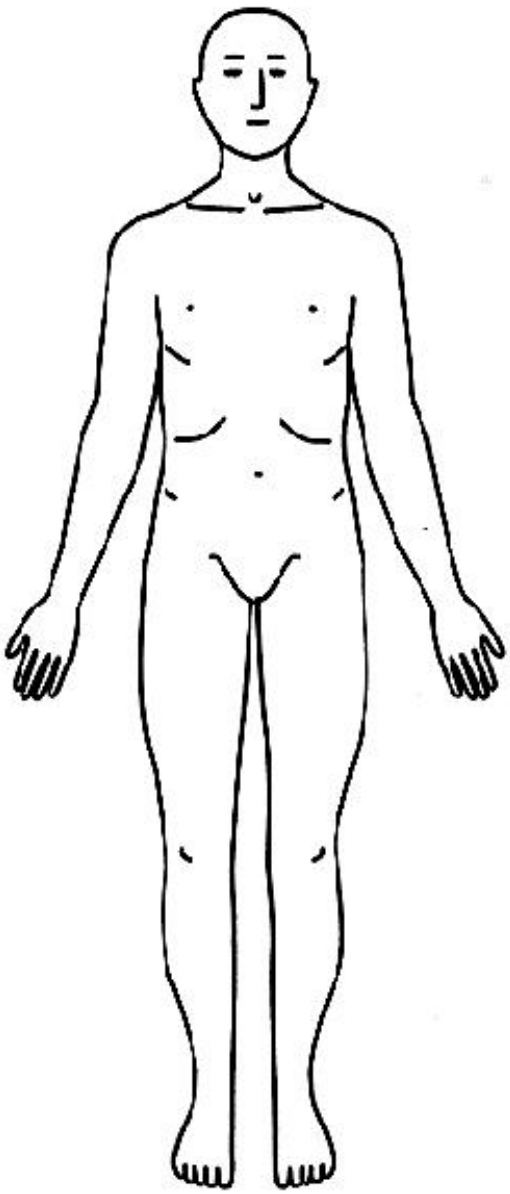
PHONE NUMBER IF DIFFERENT FROM ABOVE:

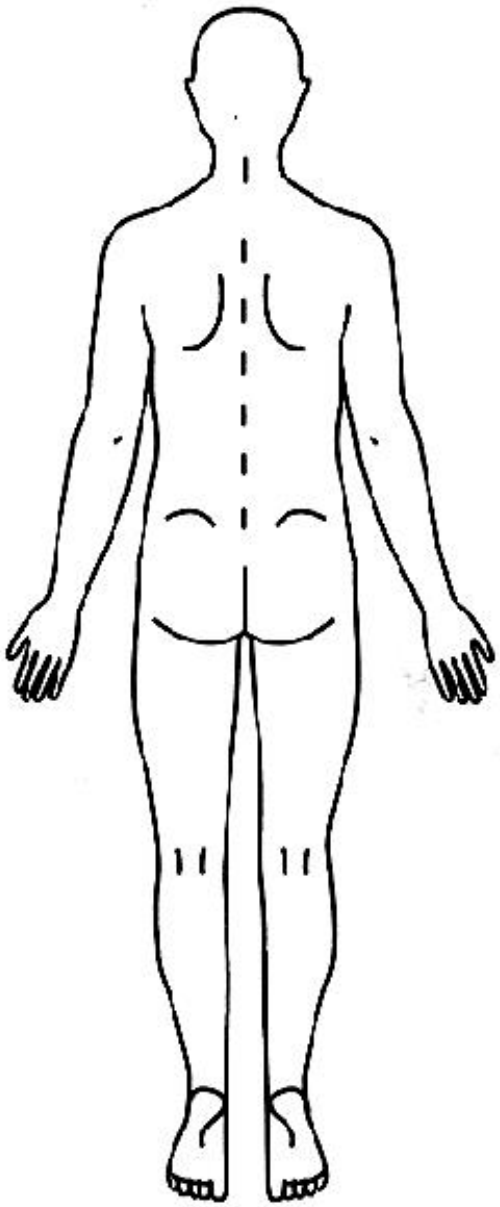
_____

PATIENT / GUARDIAN SIGNATURE(IF PATIENT IS UNDER 16) **DATE** **WITNESS SIGNATURE**

Achy or Constant Pain	XXX
Sharp Pain	****
Stiffness	////
Numbness	ooo
Other	____

Mark the area on the picture below with the appropriate symbol to best illustrate your symptoms.





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PHYSIOTHERAPY GOALS AND OUTCOME FLOW SHEET

DATE: _____

Patient: _____ DOB: _____ AGE: _____

1: List 3 activities that you are unable to do or have difficulty doing TODAY because of your problem. Some examples might be: sleeping, sitting, walking, stairs, driving, reaching up, carrying and or dressing. Please be as specific as possible. (if you don't have 3 activities, that is okay).

3 ACTIVITIES						
1.						
2.						
3.						
Percentage Improvement*(therapist only)*						
Pain Measure *(therapist only)*						
Outcome Measure *(therapist only)*						

2.

Pain intensity

Over the past 24 hours how bad has your pain been?

Choose One

3. What are your goals for treatment? Why are you coming for treatment? Please fill out your goals in the box below so that your physiotherapist / chiropractor can work with you to achieve them.
Examples: to be able to play in a soccer tournament in two weeks, to understand your condition, to decrease the pain, to get a home exercise program ....etc.

Patient Goals	**Goals reached on D/C Yes/No/ Partially (**therapist only**)**

Goals and Timeframes discussed with patient _____

Discharge planning discussed with patient _____

_____

Therapist's Name (please print)

_____

Therapist's Signature

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PHYSIOTHERAPIST INFORMED CONSENT

As a matter of ethics and law there is an obligation, prior to examination and treatment, to disclose any material risk to the patient to obtain a valid informed consent. As part of the physiotherapy treatments, certain procedures and devices may be utilized such as the use of heat, ice, electrotherapy, ultrasound, massage and manual therapy. As part of the rehabilitation program (kinesiologist, occupational therapist or physical therapist assistant) certain testing procedures, devices and equipment may be utilized such as weight machines, exercise, cardiovascular work and functional tasks. I have had the opportunity to discuss with the physiotherapist and/or other clinical staff, the nature and purpose of treatments. I understand the results are not guaranteed. I further understand, and I am informed that there are some very slight risks to treatments, including, but not limited to, muscle strains, sprains, disc injuries, and burns have been made aware that there are remote chances of injury and that appropriate tests will be performed to help identify if I may be susceptible to risk or injury

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

NOVO HEALTHNET LIMITED

CONFIDENTIAL CONSENT, AUTHORIZATION & DIRECTION TO DISCLOSE PERSONAL INFORMATION

I, _____
(Print Full Name)

Of_____
(Print Full Address)

Hereby consent to the sharing and / or exchange of written and/or verbal information between Novo Healthnet Limited and:

_____

_____

_____
(Print full names and institutions of affiliation)

In respect of

_____
(Print name of the client)

_____
(Date of birth)

Information to be released related to the above-named injury or illness and pertains to the development of treatment and nutritional plans.

I understand that this consent is subject to revocation at any time, except for such action that has already been taken.

A photocopy of this authorization shall have the same validity as the original.

Dated the _____ day of _____, 20____

_____ _____

(Witness) **(Signature)**

Cancelation Policy

DATE: _____

Name: _____ DOB: _____
DOL: _____ Claim #: _____

We understand that unplanned issues may come up and you will need to cancel an appointment. If this happens, we respectfully ask that you notify us at least 24 hours prior to your appointment time.

Our therapists want to be available to meet your needs as well as the needs for all of our patients. When a patient does not show up for a scheduled appointment, another patient loses the opportunity to be seen.

If we are not provided with the appropriate notice, you will be responsible for a Missed Treatment charge of $50.00. For any Missed Massage Treatment, you will be charged in accordance with the RMTAO as follows: 2nd missed massage – 50% of the massage fee / 3rd missed massage – 100 % of the massage fee.

This charge will not be billed to any third-party payors, you will be billed, and it must be paid by you for you to continue to be treated under your claim. Under certain circumstances management may waive this fee.

By signing below, you understand and agree to the cancelation and payment policy.

_____ _____
Patient's Name Witness Name

_____ _____
Patient's Signature Witness Signature