Physiotherapy Intake

Name _____ Sex: M F Date of birth (mm/dd/yyyy) _____ Today's Date_____

Care Card # _____ Home Phone _____ Work Phone _____ Cell Phone_____

Address _____ City_____ Province_____ Postal _____

Would you like appointment reminders? → □ Email_____ □ Text □ None

Medical Doctor_____ Who referred you to this clinic? Google / Drove By / Friend / Fix Healthcare Sign / Other_____

Is this an ICBC claim? Would you like us to do direct billing for you? (ICBC / Lawyer): Y / N Claim#_____

Injury Date _____ Adjustor's name_____ Adjustor's # _____ Lawyer (if applicable) _____

Who did you see for the first treatment after your injury? (name / occupation): _____

Please note that we do not accept WCB claims. Please notify reception immediately if you have come in for treatment for a workplace injury.

Please circle your insurance company below if you would like us to direct bill them for you:

Chambers of Commerce Group Insurance Plan · Cowan · the co-operators · Great-West Life · gsc · Industrial Alliance · Johnson · JohnstonGroup · Manulife Financial · Maximum Benefit · Pacific Blue Cross · Standard Life · Sun Life Financial

Plan # _____ Id # _____Primary's full name (if not you) _____

Primary's birthdate (mm/dd/yyyy) _____ Primary's Plan # _____ Primary's Id # _____

Describe the nature of your current symptoms: _____

When did your symptoms start? _____

What do you think started this problem? _____

Is your family physician aware? Y / N _____

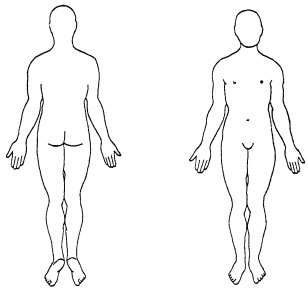
Are your symptoms getting better/worse/same since this started? _____

Have you had any testing (x-ray, MRI, CT, any other tests) recently or in the past? Y / N When: _____

Have you had this issue before? Y / N When: _____

Please mark the areas on the diagram where you feel any symptoms:

X = dull/achy pain O = Numbness/tingling
S = sharp/shooting/radiating pain # = Anything else



Do you have any abdominal or groin pain? (If yes, mark on the diagram.) Y / N

My symptoms currently: ❑ Come and go ❑Are Constant ❑ Are constant, but change with activity

What makes your pain better?

_____

What makes your pain worse?

_____

How do you sleep at night? ❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worse? ❑ Morning ❑ Afternoon ❑ Evening ❑Night ❑ After exercise

When are your symptoms better? ❑ Morning ❑ Afternoon ❑ Evening ❑Night ❑ After exercise

Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

My current pain level is: _____ In the last 24 hours, the best my pain has been is: _____ & the worst it has been is: _____

List any and all medication that you have been taking, including vitamins and over the counter medications: _____

_____

Have you ever taken any steroid medications/performance enhancers: Y / N

Have you in the past or are you currently taking blood thinning medications/anticoagulants: Y / N

Are you a smoker? Y / N Do you have a pacemaker? Y / N Are you pregnant? Y / N

Please list any and all surgeries and/or hospitalizations you have had in the past:

_____

_____

Please list any allergies: _____

Please list 3 things you are having difficulty doing because of your symptoms and give them a number from 0-10, with 0 being unable to perform and 10 being able to perform with no problem.

1. _____
2. _____
3. _____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ Fatigue
- ❑ Fever/chills/sweats
- ❑ Painful intercourse
- ❑ Nausea/vomiting
- ❑ Weight loss/gain
- ❑ Fainting / Falls
- ❑ Vision Changes
- ❑ Numbness or tingling
- ❑ Muscle weakness
- ❑ Heart palpitations
- ❑ Dizziness/lightheadedness
- ❑ Heartburn/indigestion
- ❑ Pain with deep breath
- ❑ Headaches
- ❑ Constipation
- ❑ Diarrhea
- ❑ Swollen ankles
- ❑ Shortness of breath
- ❑ Dental abscess/surgery
- ❑ Cough
- ❑ Difficulty swallowing/speaking
- ❑ Throbbing or pulsating pain in abdomen
- ❑ Changes in bowel or bladder function
- ❑ Increase in pain with eating
- ❑ Pain with bending/twisting
- ❑ Difficulty with balance while walking
- ❑ Changes in urine color/odor/flow/clarity

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ Cancer
- ❑ Heart problems
- ❑ Chest pain/angina
- ❑ High/low blood pressure
- ❑ Rheumatoid arthritis
- ❑ Blood clots
- ❑ Stroke
- ❑ Anemia
- ❑ Depression
- ❑ Lung problems
- ❑ Tuberculosis
- ❑ Asthma
- ❑ Epilepsy
- ❑ Kidney problem/infection
- ❑ Bone or joint infection
- ❑ Pneumonia
- ❑ Thyroid problems
- ❑ Diabetes
- ❑ Osteoporosis
- ❑ Multiple sclerosis
- ❑ Ulcers
- ❑ Liver problems
- ❑ Hepatitis
- ❑ Pelvic inflammatory disease
- ❑ Circulation problems
- ❑ Other arthritic condition
- ❑ Bladder/urinary tract infection
- ❑ Eye problem/infection
- ❑ Sexually transmitted disease/HIV
- ❑ Drug/alcohol dependency

If cancer, what type of cancer and what treatments have you had: _____

Other conditions not listed above: _____

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions?

- ❑ Cancer
- ❑ Heart problems
- ❑ Diabetes
- ❑ Stroke
- ❑ Tuberculosis
- ❑ Thyroid problems
- ❑ Depression
- ❑ Blood clots
- ❑ High blood pressure

During the past month have you been feeling down, depressed or hopeless? Y / N

During the past month have you been bothered by having little interest or pleasure in doing things? Y / N

Is this something with which you would like help? Y / N / Yes but not today

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? Y / N

In consideration of other patients and other practitioners, a minimum of 24 hours' notice is required to change or cancel appointments. This time has been reserved for you and unattended appointments prevent practitioners from seeing other patients. Patients will be expected to cover the full treatment fee in the case of missed appointments or late cancellations that cannot be booked by another patient. Please be advised that non-attended appointments cannot be billed to insurance providers. Thank you for your consideration.

If I am using my extended benefits, I authorize Fix Healthcare to direct bill online on my behalf and receive payment for my treatments directly. I agree that I will be responsible for any fees which are not covered by my insurance, including those which may be initially accepted but later refused by my insurance.

_____ _____

Patient Signature Date

Please fill out this consent if you are eligible for Premium Assistance and would like us to bill on your behalf:

Assignment of Medical Services Plan Benefits to Opted-Out Practitioner

I, _____ (beneficiary) authorize the Medical Services Plan to pay my Practitioner directly for all reimbursements for benefits payable to me under the Medical and Health Care Services Regulation for care provided to me by said Practitioner.

I make this assignment in full knowledge of the amount that I will be personally responsible for the patient portion of the fee and the amount that is reimbursable by the Medical Services Plan ($23.00). The amount reimbursed by MSP will be directed to the Practitioner checked above and be applied against any outstanding monies I owe for services provided. This form allows the practitioner to receive your MSP reimbursement directly for services that are MSP benefits. Our practitioner, by law, must advise you of his/her full fee and what portion will be reimbursed by MSP. By agreements, your practitioner may not charge you the portion reimbursable by MSP. **I understand that any appointments I receive over and above the 10 subsidized treatments per year will be my responsibility to pay at the private fee rates.**

Patient's Name: _____ (please print) Care Card Number (PHN): _____

Signature:_____ Date:_____