Alton PHYSIOTHERAPY & SPORTS CLINIC

4040 Palladium Way, Unit 5. Burlington, ON L7M 0V6
Tel: (905) 335-6100 Fax: (905) 335-6160

Client Name: ______________________ Date of Birth: ______________

Has your address changed? ☐ Yes ☐ No Occupation: ______________ Gender: ☐ M ☐ F

Address: ______________________ Home Phone: ______________

City, Province: ______________________ Cell Phone: ______________

Postal Code: ______________________ Other Phone: ______________

Email: ____

Please indicate with a check mark if you would like to receive text messages, emails or newsletters.

☐ I consent to have Alton Physiotherapy communicate with me via text message to the **cell number** specified above. **Initials:** _____

☐ I consent to have Alton Physiotherapy send my appointment reminders to the **email address** specified above

☐ I would like to receive the electronic newsletter or other electronic communications from Alton Physiotherapy

Were you referred to us? ☐ Yes ☐ No Please tell us how you found us ______________

Family Doctor: ______________________ City of Practice: ______________

Have you been or are you currently being treated using the following services? (please check all that apply)

☐ Physiotherapy ☐ Chiropractic ☐ Massage therapy ☐ Acupuncture

I certify that the information given on this form is true, and accurate to the best of my knowledge. I will notify my therapist of any future changes in my health history. I give my consent to treatment at Alton Physiotherapy and Sports Clinic. I understand the treatment may change at the therapist's discretion, and I am also aware of my right to withdraw my consent to treatment at any time.

Alton Physiotherapy & Sports Clinic is the health information custodian, and any health information you provide will not be released without your written consent.

I hereby authorize Alton Physiotherapy to obtain or release any required information pertaining to my health and rehabilitation. Information may be obtained or released to:

☐ Family Physician ☐ Auto Insurance Company (if auto accident) ☐ Employer (if WSIB)

Appointment Cancellation:

Please note that we require 1 business day notice for the cancellation of appointments.

I understand that **failure to give sufficient notice prior to cancellation, or a missed appointment, will result in a $10 cancellation fee** added to my account. Subsequent missed or late cancellations will result in a charge for the **full treatment fee**.

Payment Policy:
Payment is expected at the time of service. In the case of workplace injury or private insurance, if WSIB or the insurance company does not accept my claim, I will be responsible for all treatment costs not payable.

Waiver of Consent:

I have read and understand the above rules and procedures at Alton Physiotherapy and Sports Clinic.

______________________ ______________________
Print **patient/guardian** Name Print name of **witness**

______________________ ______________________
Signature of **patient/guardian** Signature of **witness**

Date: ______________

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HEALTH HISTORY

Please indicate (with a checkmark) which of the following you have had, where in the body and when(date):

- ☐ Car accident (date): ____________
- ☐ Work/Sports-related injury: ____________ - Body part: ____________ R / L
- ☐ Fractures: ____________ Dislocations: ____________
- ☐ Surgeries: ____________
- ☐ Have you had an X-ray or imaging for any of the above? ____________
- ☐ Metal fixations, screws, pins, plates, wires, artificial joints, limbs, or special equipment? ____________
- ☐ Medications: ____________

Please indicate with a check mark the conditions that apply to you:

Musculoskeletal

- ☐ headaches
- ☐ Jaw pain / TMJ
- ☐ Neck / shoulder
- ☐ Arm pain – Right/left
- ☐ Upper / mid back
- ☐ Low back / hip
- ☐ Leg pain – Right/left
- ☐ Knee pain – Right/left
- ☐ Tendonitis / bursitis
- ☐ Sprains / strains
- ☐ Osteoporosis
- ☐ **Arthritis**
- ☐ **"flat feet"**
- ☐ Other: ____________

Miscellaneous

- ☐ Anxiety
- ☐ Depression
- ☐ Unexplained Weight loss
- ☐ **Restless Leg syndrome**

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart disease
- ☐ Heart attack
- ☐ Pace maker/device
- ☐ Stroke / CVA
- ☐ **Varicose veins**
- ☐ Difficulty breathing
- ☐ Chronic cough
- ☐ Sinus problems
- ☐ Allergies
- ☐ Other: ____________

Infection

- ☐ Herpes
- ☐ Hepatitis
- ☐ Plantar warts
- ☐ TB
- ☐ HIV / AIDS
- ☐ Other: ____________

Nervous System

- ☐ Chronic pain
- ☐ Numbness / tingling
- ☐ Fatigue
- ☐ Insomnia
- ☐ Loss of sensation
- ☐ Other: ____________

Skin

- ☐ Allergies
- ☐ Infections
- ☐ Rashes
- ☐ Wounds / scars
- ☐ Bruise easily
- ☐ Other: ____________

Women

- ☐ Menstrual problems
- ☐ Gynaecological surgeries: ____________
- ☐ Pregnant Due Date: ____________
- ☐ Pregnant Due Date: ____________
- ☐ Other: ____________

Pathologies

- ☐ Liver
- ☐ Kidney – Right/Left
- ☐ Bladder
- ☐ Diabetes
- ☐ Cancer
- ☐ Epilepsy
- ☐ Vision loss
- ☐ Hearing loss
- ☐ **Dizziness/vertigo**
- ☐ Thyroid problem

Digestive System

- ☐ Constipation
- ☐ Irritable bowel syndr.
- ☐ Other: ____________

- ☐ Do you wear orthotics? ☐ Yes ☐ No ____________
- ☐ Do you wear compression / support socks or garments? ☐ Y ☐ N
- ☐ Do you smoke? ☐ Y ☐ N

I hereby confirm that the above information is correct, to the best of my knowledge.

____
Print Patient / Guardian Name

____________ ____________
Signature of Patient / Guardian **Date**