PHYSIOTHERAPY CLIENT INTAKE FORM

SECTION A – GENERAL INFO (All information is retained as part of your confidential record)
NAME ____ Pronoun ____________ STREET ADDRESS ____ CITY _____________________________ PROVINCE __________ POSTAL CODE ________________ HOME/CELL# ________________________________ WORK# __________________________________ DATE OF BIRTH: M______ D______ Y__________ OCCUPATION ____ EMPLOYER ____ EMERGENCY CONTACT: _________________________________PHONE # ________________________ FAMILY DR. ____PHONE # _____________________ REFERRING DR. ____PHONE # _____________________
SECTION B – INSURANCE INFO
NAME OF MEDICAL INSURANCE COMPANY: ____ POLICY/PLAN NUMBER: ____ ID NUMBER : ______________________________________

Injury third party payer (please fill out applicable section)	
ARE YOU HERE AS A RESULT OF A MOTOR VEHICLE ACCIDENT (MVA)? YES ___ NO ___ IF YES) NAME OF YOUR AUTO INSURANCE COMPANY: ____ ____ INSURANCE ADJUSTER: ____ PHONE # _______________________________________ FAX # ____ EMAIL ____ CLAIM # _______________________________________ POLICY # ______________________________________ DATE OF ACCIDENT (M/D/Y) _________________________	ARE YOU HERE AS A RESULT OF A WORKPLACE ACCIDENT? YES ___ NO ___ IS YOUR INJURY COVERED BY WSB (WORKPLACE SAFETY AND INSURANCE BOARD)? NO___ YES ___ (IF YES) WSB CONTACT NAME ____ PHONE # __________________________________ CLAIM#_____________________________________ DATE OF ACCIDENT (M/D/Y) ___________________

NB: If this is a MVA, the NS 1 form must be completed and returned to your auto insurance company. If not, you will be responsible for all fees.

WORKER'S COMPENSATION CLIENTS: If, for any reason, WSB declines to cover your Physiotherapy claim, you will be responsible to pay the outstanding balance on your account

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MSI does not cover private Physiotherapy in Nova Scotia. Therefore, you or your medical insurance company are directly responsible for payment of any services provided to you by Lisa's Holistic Rehab & Neurofeedback.

SECTION C – HEALTH HISTORY

Are you presently receiving, or have you ever received any of the following treatments for your current condition?

- Chiropractic
- Reflexology
- Massage
- Acupuncture
- Occupational Therapy
- Physiotherapy
- Naturopathic
- Podiatry/Chiropody
- Other ____

Please check any of the following conditions that you have:

- Arthritis
- Hernia
- Diabetes
- Depression
- Thyroid Condition
- Osteoporosis
- Dizziness/Fainting
- Smoking History
- Low/High Blood Pressure
- Raynauds
- Heart Condition/Disease
- Recent Falls/Blackouts
- Asthma
- Unexplained Weight Loss
- Bronchitis
- Broken Bones/Fracture
- Recent Infection (chest, urinary tract, etc.)
- Sleeping Problems
- Chest Pain
- Heart Palpitations
- Cough
- Metal Implants
- Pacemaker
- Vision Difficulties
- History of Cancer
- Swallowing Difficulties
- Allergies to tape/latex
- Slurred Speech
- Any Allergies
- Memory Problems
- Epilepsy/Seizures
- Balance Problems
- Shortness of Breath
- Cancer
- Kidney Problems
- Dizziness/Blackouts
- Groin Numbness/Tingling
- Respiratory Condition
- Bowel/ Bladder Difficulties
- Hearing Impairment
- Headaches
- Pregnancy
- Blood Diseases
- Loss of Balance
- Loss of Coordination
- Other

  ____
  ____
  ____
  ____
  ____
  ____

What do you expect/hope to achieve from therapy with us today? (the primary reason for your physiotherapy consult)

____
____

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____
____

Previous injuries/surgeries:
____
____

Is there anything else we should know about your health?
____
____

Please tell us what your (3) primary goals are or what you wish to achieve with your treatments: (e.g. return to playing tennis 3x a week, return to my full-time work, be able to walk for 30 minutes, eliminate headaches)
____
____
____

Please list any medications you are currently taking:
____
____

Please circle any test you have underwent in the last 3 months for your current complaint/condition.

X-rays CT Scan EMG/nerve conduction MRI Bone Density Study Ultrasound Other (specify)

Do you have a history of oral steroid use? (e.g. cortisone, prednisone) ___ Yes ____ No

During the last month, have you often been bothered by feeling down, depressed or hopeless?
____Yes ____ No

During the last month, have you often been bothered by little interest or pleasure in doing things?
____Yes ____ No

VISUAL ANALOG SCALE

Referring to the drawings below, please indicate where you are experiencing pain by describing the area of injury, and the scale number for your current level of pain. Please list where you are feeling the pain (I.E. neck, back, shoulder, etc.)

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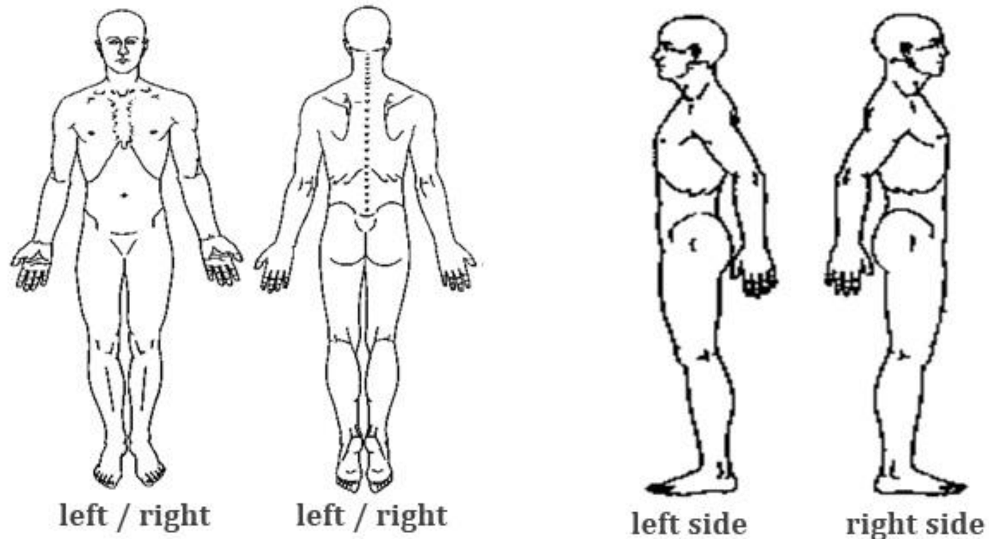

1st Area of Injury & Pain Scale: ____

2nd Area of Injury & Pain Scale: ____

3rd Area of Injury & Pain Scale:____

Is there anything else you would like to add:
____
____
____
____
____
____

CONSENT for THIRD PARTY PAYER

It is important to establish and maintain clear lines of communication with all parties involved in the successful rehabilitation of your injury. As a result, information relating to your treatment progression and treatment plans may be shared with your physician, case manager, employer and/or third party payer.

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I, ____ (please print your name), do consent to being treated/ assessed by the physiotherapist with Lisa's Holistic Rehab & Neurofeedback. I hereby authorize the release of my assessment or progress notes, or any other medical information to my: (Please fill in appropriate names)

____ (Family Physician/Specialist)
____ (Insurance Company)
____ (Workers Compensation Board)
____ (Lawyer)
____ (Physiotherapist/Other Medical____________________)
____ (Employer Representative/Other)

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