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Adult General Physiotherapy Intake Form

Name_____ Date of Birth (DD/MM/YYYY)_____

Preferred name: _____ Gender: _____

Address_____ City _____

Province _____ Postal Code __ __ __ __ __ __

Telephone Number:
Cell: _____ Home: _____ Work: _____

Email Address: _____

Preferred method of Contact: Email Home Phone Cell Phone Work phone

Occupation: _____ Employer:_____

Emergency Contact: _____ Relationship:_____

Phone #: _____

Injury area: _____ Injury Date: _____

General Health conditions (Blood pressure/Heart Condition/Arthritis/etc.):

_____

Past Injuries: _____

Major Surgeries: _____

Medications (including over the counter and natural health products):

_____

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Allergies (medication, environmental, food, etc):

_____

Family Physician (First name, Last name, and Name of Clinic):

_____

Phone number to clinic: _____

Other Current Healthcare Providers:
Name: _____ Specialty: _____
Phone: _____

Name: _____ Specialty: _____
Phone: _____

Health Habits

What behavioral or lifestyle activities are you currently engaged in to promote your health?

_____
_____

What behavioral or lifestyle activities are you currently engaged in that could be harming to your health?

_____
_____

Do you exercise regularly? Y N What form and how often? _____
_____

Do you currently smoke or vape nicotine? Y N If yes, amount/day? _____

Do you regularly drink alcohol? Y N If yes, how much and how often? _____

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How did you hear about us at Little Oak Wellness?

Patient Referral	Media (Radio)	Social Media
Advertising (Brochure/poster)	Website	Google
Friend Referral	Family Referral	Other: _____

Ontario Health Insurance Plan (OHIP) Information:
12 digit # on front of card ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ - ___ ___

Have you received an x-ray or MRI for your condition being assessed today ? Y N
If yes, where was it done? _____

Cancellation Policy

_____ **Initial** In order to keep appointment running smoothly, we ask that you arrive at your appointment in a timely manner. Patients arriving more than 15 minutes late will be considered a "no-show" and will be required to reschedule their appointment for another time. If it is necessary that you cancel your appointment, we ask for 24 hours' notice prior to your appointment time.

_____ **Initial** Any patient who fails to come to an appointment without notice to the clinic, **will be charged the full fee of the missed appointment.** Any patient who arrives more than 15 minutes late needing to reschedule the appointment, or who cancels less than 24 hours prior to their appointment **will be charged 50% of their appointment fee.**

Collection of Personal Information
Personal information is collected under the *Regulated Health Professionals Act* and related legislation and in accordance with the *Personal Health Information Protection Act.* We collect only the personal information needed to provide service. Your information may be shared with others as required or permitted by law. For more information please ask to see our full Privacy Policy or see the privacy statement on our web-side at www.littleoakwellness.ca

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Circle of Care Policy

In order to provide optimal care in an integrated, complimentary health clinic, a circle of care model is beneficial. Information will only be shared with practitioners within Little Oak Wellness Center or with other practitioners in your circle of care. Practitioners will not have direct access to your records unless you have provided direct consent. Only the minimum amount of information will be shared to ensure quality of service is provided and information transfers are done in a secure manner. For more information, please request to see our full Privacy Policy.

- I hereby consent to treatment and to the release of medical information pertaining to my injury to other medical personnel within my circle of care.
- I consent to the release of medical information pertaining to my injury as described in requests by my treating physiotherapist from other medical facilities within my circle of care.
- I understand that in the event that my insurance company does not cover the costs of Physiotherapy, I will be financially responsible for payments.

Please sign below indicating that you have read and acknowledge the above outlined policies at Little Oak Wellness Center.

Signature: _____ Date: _____