Patient Intake Form

Patient Name: _____ Date of Birth: _____/_____/_____
Last First Day Month Year

Address: _____

City: _____ Home Tel: _____

Postal Code: _____ Other Tel: _____

*E-mail: _____

Occupation _____ Employer _____

Emergency Contact (Name)_____Phone_____

Family Physician _____ Phone_____

Physician Address _____
Address City

Referring Physician _____ □ same as above

***By adding your email, we will send you appointment reminders, your home exercises and occasional newsletters – your email will never be shared with any other organization.**

How did you find the clinic? (please provide details)

□ Doctor/Other Professional (Name) _____
□ Internet (Google, Yahoo, Facebook, Twitter)_____
□ Family/Friend (Name) _____
□ Other _____

For WSIB/MVA patients only:

Claim # _____Policy # (if applicable)_____
Date of Injury _____
Employer's Name _____ Contact Person _____
Address: _____

SIN # _____ Health Card #_____
Adjuster/Case Manager's Name _____
Phone _____Fax_____ Email_____
Auto Insurance Company (if applicable) _____
Extended Health Care Provider (if you have coverage)_____

Cancellation and No Show Policy

I understand that the clinic requires **reasonable notice for cancellation** of appointments. I also understand that **I may be charged if I do not attend** for scheduled appointments. We define **reasonable notice as 24 HOURS**, with exceptions for emergency, adverse weather and unexpected illness.

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Policy

I understand that payment for services received at the clinic is my responsibility, and fees are payable at the time of my appointment. I understand that the fees per visit for these services are:

Assessment & Initial Visit $**120** Follow up Treatment sessions **$75** _____Initials

If you wish to carry a balance between treatments, or pay weekly, or we are billing to any third party, we require a valid credit card on file. We will bill any owed amounts in your account at week end and issue a receipt.

CARD #_____EXPIRY#_____ _____Initials

Consent to Assessment and Treatment

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

   _____ Family Physician _____ Insurance Company (if MVA) _____ Employer (if WSIB)

2. **I consent to being assessed by a Pure Physiotherapist which may include treatment. I will be informed of the treatment Pros and Cons by the Physiotherapist and am also aware of my right to withdraw my consent, verbally, to treatment, at any time.**

3. **I have read / understood the Clinic's 24 hour cancellation policy. Initial: _____**

If any third party payer (insurance company) refuses to pay for my claim, I accept responsibility for any unpaid balance on my account. Initial: _____

Consent to the Collection, Use and Disclosure of Personal Health Information

Note to client: We want your informed consent. We want you to understand what we do with the personal health information we collect about you. Please ensure that you have read and understood our written statement, "Our Privacy Commitment to You". If you have any questions, please ask.

I, _____, understand that to provide me with physiotherapy, Pure Physiotherapy will collect personal information about me (e.g., birth date, home contact information, health history, etc.).

I have reviewed the Pure Physiotherapy's written statement on the collection, use and disclosure of personal health information. I understand how the written statement applies to me. I have been given a chance to ask questions about the Pure Physiotherapy's privacy policies and they have been answered to my satisfaction.

I understand that Pure Physiotherapy will only collect, use or disclose my personal health information with my express or implied consent, unless a collection, use or disclosure without consent is permitted or required by law.

I understand that I can withdraw my consent at any time by contacting: Joanna Nelken
I agree to Pure Physiotherapy collecting, using and disclosing personal health information about me as set out above and in the written statement.

Signature: _____ Printed Name: _____

Date: _____

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COVID-19 HEALTH SCREENING QUESTIONNAIRE

	Yes	No
Have you had close contact with anyone with acute respiratory illness or have you travelled outside Ontario in the last 14 days	□	□
Do you have a confirmed case of Covid-19 or have you had close contact with a Confirmed case of Covid-19?	□	□

Do you have any of the following?

Fever	□	□
New onset of cough	□	□
Worsening chronic cough	□	□
Shortness of breath	□	□
Difficulty breathing	□	□
Sore throat	□	□
Difficulty swallowing	□	□
Decrease or loss of sense of taste/smell	□	□
Chills	□	□
Headaches	□	□
Unexplained fatigue/malaise/muscle aches	□	□
Nausea/vomiting, diarrhea, abdominal pain	□	□
Pink eye (conjunctivitis)	□	□
Runny nose/nasal congestion without other known cause	□	□

If you are over 70 years of age, are you experiencing any of the following symptoms:

	Yes	No
Delerium	□	□
Unexplained/increased number of falls	□	□
Acute functional decline	□	□
Worsening of chronic conditions	□	□

Name:_____

Signature: _____ Date:_____

Witness Name (printed):_____ Witness Signature: _____

Date: _____

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Name_____Age_____Occupation_____

Current symptoms/cause/duration: _____

_____

Please list any other treatment or consultations you have had to address this problem in the past:

_____

_____

_____

Please list any medications you are taking (including dose and frequency):

_____

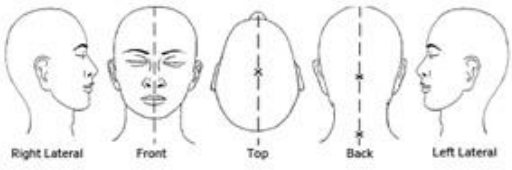
_____

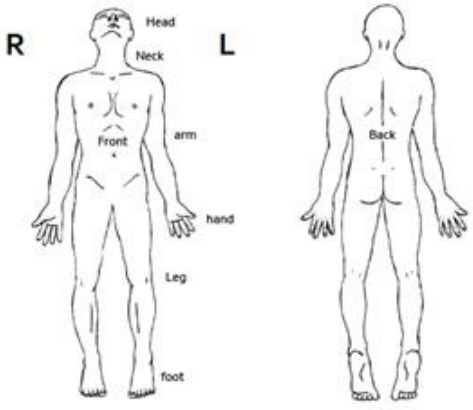
_____

Please list if you've had any diagnostic imaging (XRay/MRI/CT/Ultrasound) for the relevant areas and when they were performed:

_____

_____





Please indicate where you feel your symptoms. Be as specific as you can (do you feel tingling, burning, etc…)

Please rate your pain out of 10 (10 being the worst pain imaginable):

At rest: /10 During aggravating activities: /10

What activities/postures make your pain worse?

_____

_____

What activities/postures make your pain better?

_____

_____

	Yes	No
Asthma	□	□
Allergies	□	□
Cardiac Problems	□	□
Cardiac Pacemaker	□	□
Respiratory Problems	□	□
High Blood Pressure	□	□
Diabetes	□	□
History of Stroke	□	□
Cancer	□	□
Epilepsy/Seizure	□	□
Hearing Problems	□	□
Vision Problems	□	□
Are you pregnant?	□	□

Does your medical history include any of the following? Please describe:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Infectious Skin Condition	□	□	_____
Hepatitis	□	□	_____
Other	□	□	_____

Signature: _____ Date: _____

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Electronic Transmission Authorization and Consent Form

Instructions: This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years following closure of the patient file.

Provider: PURE PHYSIOTHERAPY
Address: 1-114 Lakeshore Rd West
City/Province: Mississauga, Ont.
Postal Code: L5H 1E8
Phone Number: 905-891-7873

Patient: _____
Address: _____
City/Province: _____
Postal Code: _____
Phone Number: _____
Plan Number: _____
Certificate / Plan member Number: _____

Insurance Company: _____
Name of Insured: _____
Relationship: _____

Consent to Collect and Exchange Personal Information

Message to the Plan member, Spouse and/or Dependent regarding Personal Information

Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependents, is used by the insurer and/or plan administrator and their service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and / or plan abuse.

Authorization and Consent

I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize the insurer and / or plan administrator and their service provider(s) to:

- Use my personal information for the above purposes.
- Exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes.
- Exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member.
- Exchange personal information for the above purposes electronically or in any other manner.

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

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Additional Consent Applicable to Plan Members Only

I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.
In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.
If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

Signature: _____ Date:_____

Print Name:

Benefit Assignment Form

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.
I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.
I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.
If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

Signature: _____ Date:_____

Print Name:_____

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Integrated Dry Needling Consent

Integrated Dry Needling (IDN) involves inserting a tiny monofilament needle in a muscle or muscles in order to release shortened bands of muscles and decrease trigger point activity. This can help resolve pain and muscle tension, and will promote healing. This is not traditional Chinese Acupuncture, but is instead a medical treatment that relies on a medical diagnosis to be effective. Your physical therapist is trained as a certified Integrated Dry Needling Practitioner.

IDN is a valuable and effective treatment for musculoskeletal pain. Like any treatment, there are possible complications. While complications are rare in occurrence, they are real and must be considered prior to giving consent for treatment.

Risks: The most serious risk with IDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe puncture can require hospitalization and re-inflation of the lung. This is a rare complication, and in skilled hands it should not be a major concern. Other risks include injury to a blood vessel causing a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern.

Patient's Consent: I understand that no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. My therapist has also discussed with me the probability of success of this procedure, as well as the probability of serious side effects. Multiple treatment sessions may be required/needed, thus this consent will cover this treatment as well as consecutive treatments by this facility. I have read and fully understand this consent form and understand that I should not sign this form until all items, including my questions, have been explained or answered to my satisfaction. With my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

Does your medical history include any of the following? Please describe:

	Yes	No	
Are you pregnant?	□	□	_____
Are you taking blood thinners?	□	□	_____
Do you have a clotting disorder?	□	□	_____
Are you allergic to surgical steel?	□	□	_____
Are you allergic to skin prep chemicals?	□	□	_____
Are you immunocompromised?	□	□	_____
Do you have a local infection?	□	□	_____
Joint replacement or intra-articular hardware?	□	□	_____
History of bacterial endocarditis?	□	□	_____
Heart valve replacement?	□	□	_____
Recent surgery?	□	□	_____

Name:_____

Signature: _____ Date:_____

Witness Name (printed):_____ Witness Signature: _____

Date: _____

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Informed Consent to Manipulative Therapy

Manipulation (for the spine and peripheral joints) is a treatment technique within the practice of manual therapy that involves specialized hands-on treatments applied by highly qualified physiotherapists. **A manipulation is a passive, high velocity, low amplitude thrust** applied to a joint beyond its physiological limit of motion, but within its anatomical limit, with the intent to restore optimal motion and function, reduce muscle pain and tension and/or reduce pain.

CAMPT-Certified Physiotherapists are **Fellows of the Canadian Academy of Manipulative Physiotherapy (FCAMPT)** and have advanced training and clinic expertise in manual and manipulative therapy. They are required to have completed extensive post-graduate education in the area of orthopaedics and have attained internationally-recognized qualifications in hands-on manipulative therapy. CAMPT-Certified physiotherapists are qualified to provide safe and effective treatments for pain and movement disorders of the spine and extremities.

Physiotherapists who use manual therapy techniques such as manipulations are required to advise patients that there are some risks associated with such treatment. Physiotherapists obtain informed consent to treatment in accordance with provincial legislation governing their practice. Clients are routinely reassessed following a manipulation and treatment is continued, modified, or discontinued based on the results of this evaluation, and when indicators for manipulation and/or established treatment goals are met.

In particular, you should note that while rare, some patients have experienced: exacerbation and aggravation of symptoms including increased pain and stiffness, muscle strain, ligamentous sprain, muscle spasm and bruising following manipulations.

In spinal manipulations some of the risks may include rib fracture, vertebral fractures, spinal disc injury including disc herniation and bulges, spinal cord injury , myelopathy , central cord syndrome, or quadriplegia, neurological injury or impairment including radiculopathy, numbness, tingling, pins and needles, and radiating pain.

There have been reported cases of injury to the vertebral artery (blood vessel located in the neck) following manipulation to the neck (cervical spine). Vertebral artery injuries have been known to cause dizziness or vertigo, or at their worst stroke, sometimes with serious neurological impairment, or death. The possibility of such injuries resulting from neck spinal manipulation is extremely rare and occurs almost entirely in the top-most region.

Physiotherapy treatment, including manipulation, has been the subject of government reports and multi-disciplinary studies conducted over many years. These reports and studies have demonstrated treatment to be effective for spinal pain, headaches and other similar symptoms. These treatments may contribute to your overall well-being. The risk of injuries or complications from treatment is substantially lower than that associated with the other treatments, medications and procedures given for the same symptoms.

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Does your medical history include any of the following? Please describe:

	Yes	No	
Are you pregnant?	□	□	_____
Have you had a recent trauma (< 6 weeks)?	□	□	_____
Do you have any healing fractures/dislocations?	□	□	_____
Do you have osteoporosis? Paget's disease?	□	□	_____
Do you have any past or present cancers?	□	□	_____
If yes, indicate if it was breast, bronchus, prostate, thyroid, kidney, bowel or lymphoma			
Do you have an inflammatory disease/disorder?	□	□	_____
(rheumatoid/psoriatic arthritis, ankylosing spondylitis, Reiter's syndrome)			
Do you have a collagen disease?	□	□	_____
Do you have an active infection? (ie osteomyelitis, tuberculosis)	□	□	_____
Do you have any congenital abnormalities?	□	□	_____
Do you have any bladder or bowel dysfunction?	□	□	_____
Do you have a history of dizziness, vertigo, nausea and vomiting, tinnitus or nystagmus?	□	□	_____
Are you taking blood thinners?	□	□	_____
Do you have a clotting disorder?	□	□	_____
Are you taking steroids?	□	□	_____
Are you immunocompromised?	□	□	_____

I acknowledge, I will discuss, with my therapist, the nature and purpose of treatment in general and my treatment in particular as well as the content of the Consent.

I acknowledge that I have the right to refuse manipulation and manual therapy techniques, regardless of the consequences and regardless how beneficial or necessary such treatment may be.

I consent to and authorize my physiotherapist, or whomever he/she may designate, to perform manipulation (spinal and peripheral techniques as needed) and manual therapy techniques on me, and agree to proceed with such treatment.

This consent applies to all my current and future treatment.

I acknowledge that I have the right to withdraw my consent and stop treatment at any time.

Name (printed):_____ Signature: _____

Date: _____

Witness Name (printed):_____ Witness Signature: _____

Date: _____