body works

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All information is strictly confidential under the Provider-Patient relationship and nothing will be released unless instructed to do so by the patient.

PATIENT INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Occupation:_____
(DD/MM/YYYY)

Address:_____

City: _____ Province:_____ Postal Code:_____

Home:_____ Emergency Contact: _____

Work: _____ Contact number: _____

Cell: _____ Relationship: _____

Email:_____

Medical Doctor:_____ PEI Health card no: _____

INSURANCE INFORMATION

We can bill most private health insurance plans directly.

☐ If you do NOT have insurance, please tick this box and proceed to the next section.

Insurance Provider: _____ Policy/Group/Plan number: _____

ID number: _____ If you are not the policy holder, complete below:

First & last name: _____ Date of Birth: _____

Relationship to policy holder: ☐ Spouse ☐ Child Other: _____

MEDICAL HISTORY/ INFORMATION

Prior Physiotherapy Care? ☐ Yes ☐ No Treatment Provider: _____

Date of last Visit: _____ Results: Excellent Good Fair Poor

Other care? Chiropractic: ☐ Current ☐ Previous Massage Therapy: ☐ Current ☐ Previous

Other:_____ ☐ Current ☐ Previous

What is the complaint you are seeking treatment for? _____

_____

How/when did the problem begin? _____

What type of pain have you been experiencing? Tick all that apply:

☐ Sharp ☐ Stab ☐ Twinge ☐ Dull ☐ Ache ☐ Throb ☐ Burn Other: _____

Do you exercise? If yes, please describe: _____

_____

List any medications/vitamins you are currently taking:

_____

_____

List any fractures/loss of consciousness/major traumas/falls or accidents:

_____

_____

Have you ever been hospitalized or had any surgeries/operations? If yes, please list with dates:

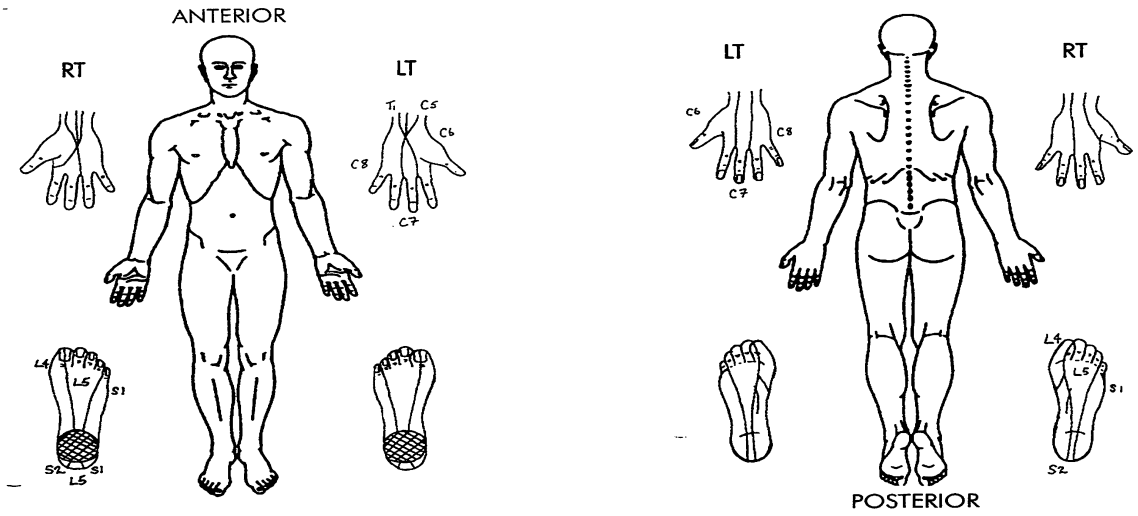
_____

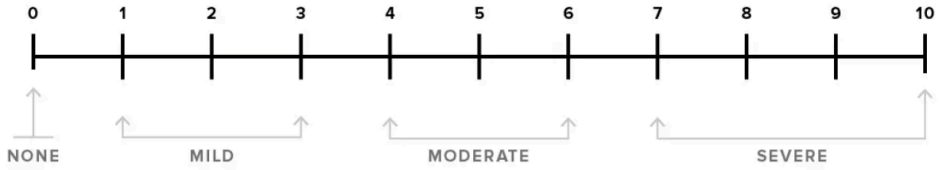
_____

_____

Do you:	Smoke cigarettes?	☐ Yes	☐ No	☐ Occasionally
	Consume alcohol?	☐ Yes	☐ No	☐ Occasionally
	Consume cannabis?	☐ Yes	☐ No	☐ Occasionally

Please circle area(s) of concern:





Using the numeric pain scale above, please indicate on a scale of 1 to 10…

- The current level of pain you are experiencing: _____ out of 10
- The worst level of pain you have experienced over the last 14 days: _____ out of 10
- The lowest level of pain you have experienced over the last 14 days: _____ out of 10
- The average level of pain you have experienced over the last 14 days: _____ out of 10

Family Health Conditions (tick all that apply to your immediate family members):

- ☐ Asthma
- ☐ Birth defects (such as spina bifida or a cleft lip)
- ☐ High blood pressure (hypertension) or high cholesterol
- ☐ Genetic conditions (such as cystic fibrosis or haemophilia)
- ☐ High blood pressure (hypertension) or high cholesterol
- ☐ Heart disease or sudden heart attack
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Mental illness
- ☐ Cancer
- ☐ Diabetes
- ☐ Other: _____

Personal Health Conditions (tick all that apply to you):

- ☐ Aneurysm
- ☐ Diabetes
- ☐ Heart conditions
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Fatigue
- ☐ Pleurisy
- ☐ Polio
- ☐ Stroke
- ☐ Asthma
- ☐ Epilepsy
- ☐ Other: _____
- ☐ Cancer
- ☐ Difficulty sleeping
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Allergies: _____
- ☐ Respiratory conditions
- ☐ Anxiety/Depression
- ☐ Sinus conditions
- ☐ Hepatitis/HIV/V.D.

CONSENTS

Accuracy of Information
I certify that the above medical information is correct to my knowledge.

"Open Concept" treatment
I understand that Body Works Physiotherapy uses an "open concept" method of treatment where other patients may be receiving treatment at the same time.

Privacy and Sharing of Information
I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Cancellation policy
Your appointment time is reserved just for you. A late cancellation or missed visit leaves a gap in the therapist's day that could have been filled by another patient. As such, we require 24 hours notice for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss their appointment, will be charged a cancellation fee of 50-100% of the service cost.

Consent to examination and treatment
I hereby request and consent to the performance of physiotherapy procedures, including therapeutic exercise and dry needling. I understand that results are not guaranteed. As in all health care, there are some slight risks involved with the performance physiotherapy procedures, including therapeutic exercise. These risks include, but are not limited to the following: stroke, stroke-like events, disc injury, rib dysfunction, fracture, muscle strain or sprain, perforated lung. I do not expect the Physiotherapist to be able to anticipate and explain all risks and complications, and I wish to rely on the Physiotherapist to exercise judgement during the course of the procedure which the Physiotherapist feels at the time, based upon the facts then known, is in my best interest.

The history and examination procedures performed on all new patients are designed to identify patients with risk factors, and to aid in the planning of your therapy. The treatment methods used will be selected so as to be as comfortable and safe as possible. If you have any questions or concerns, please feel free to discuss them with your Physiotherapist.

I agree to the above mentioned physiotherapy, therapeutic exercise and/or dry needling procedures. I intend this consent to cover the entire course of treatment for my present condition.

Name: _____ **Date**: _____
Please print *DD/MM/YYYY*

Signature: _____