

**Confidential Patient Information**

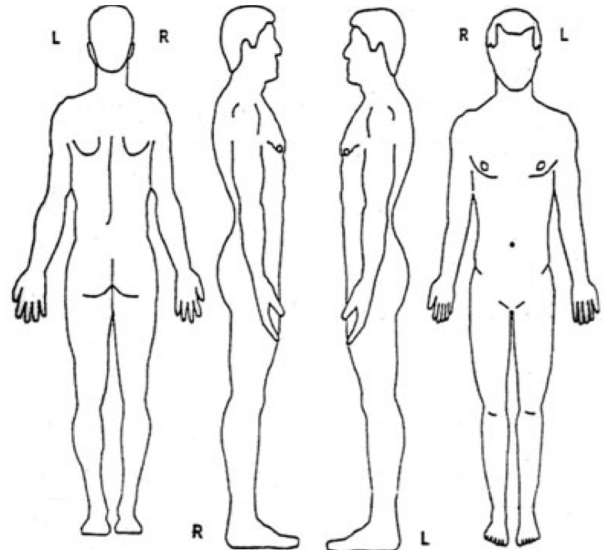
Title: \_\_\_ Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_ Gender: M / F  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Home Ph #: \_\_\_\_\_ Work Ph #: \_\_\_\_\_ Cell Ph #: \_\_\_\_\_  
 E-mail: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Medicare #: \_\_\_\_\_ Do you have Insurance? Yes / No \_\_\_\_\_  
 Who recommended you to this clinic? \_\_\_\_\_  
 Family Doctor: \_\_\_\_\_ Clinic: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Ph #: \_\_\_\_\_

**PRIMARY REASON FOR ASSESSMENT:** \_\_\_\_\_

How severe is your pain?

\_\_\_\_\_

No pain Worst pain imaginable



How would you describe the problem? \_\_\_\_\_  
 What caused your present condition? \_\_\_\_\_  
 How long have you had this condition? \_\_\_\_\_ Where does the pain radiate?  Arm  Leg  Nil  
 When is the condition worse?  Morning  Evening  During the night Is it waking you at night?  Yes  No  
 Does anything aggravate the condition?  Lying  Standing  Sitting  Movement  Other \_\_\_\_\_  
 Does anything relieve the condition?  Yes  No If yes, please explain \_\_\_\_\_  
 The condition is:  Getting Better  Getting Worse  Staying the Same  
 Have you had Treatment for this condition?  Yes  No By Whom: \_\_\_\_\_ Result: \_\_\_\_\_  
 Have you ever consulted a Physiotherapist?  Yes  No If yes, when? \_\_\_\_\_

Have you recently experienced any of the following? (Please write "Y" for Yes or "N" for No & circle those that apply)

Fever/Nausea/Vomiting \_\_\_ Night Pain/Sweats \_\_\_ Unexplained Weight Loss \_\_\_  
Bowel/Bladder Habit Change \_\_\_ Difficulty to Speak/Swallow \_\_\_ Dizziness/Vertigo \_\_\_  
Visual/Hearing Problems \_\_\_ Fainting/Light-Headedness \_\_\_ Numbness in Groin Region \_\_\_

Do you smoke tobacco? Yes / No If yes, how many per day? \_\_\_\_\_  
Do you drink alcohol? Yes / No If yes, how many per day? \_\_\_\_\_  
Do you use recreational drugs? Yes / No If yes, which? \_\_\_\_\_ How often? \_\_\_\_\_

**Do you have a Pacemaker? Yes / No**

Do you take any Medications? Yes / No If yes, which? \_\_\_\_\_  
Do you take any Supplements? Yes / No If yes, which? \_\_\_\_\_

In your lifetime, have you ever experienced any of the following: (Please be specific)

- Broken Bones: \_\_\_\_\_
- Dislocations: \_\_\_\_\_
- Infections: \_\_\_\_\_
- Hospitalizations: \_\_\_\_\_
- Surgeries: \_\_\_\_\_
- Cancer/Diabetes/Stroke: \_\_\_\_\_
- Other: \_\_\_\_\_

If you are Female, is there any chance you could be Pregnant? Yes / No / Maybe

Do you engage in regular physical activity? Yes / No If yes, which? \_\_\_\_\_

How many times per week do you engage in physical activity? \_\_\_\_\_ Is it high intensity? Yes / No / Rarely

What is the average duration of physical activity?  <10min  10-20min  20-30 min  30-60 min  >60 min

**Informed Consent to Physiotherapy Treatment**

I understand that the physiotherapist is providing healthcare services within their scope of practice as defined by governing bodies of physiotherapy in New Brunswick. I hereby consent for my physiotherapist to treat me for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my physiotherapist.

I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.

I acknowledge and understand that the physiotherapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my physiotherapist and disclosed all of those medical conditions affecting me. It is my responsibility to keep the physiotherapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I authorize my physiotherapist to release or obtain information pertaining to my condition(s) and/or treatment to/from my other caregivers or third party payers. Furthermore, I consent to having my healthcare information stored on protected servers within Canada or abroad.

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my physiotherapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

**Date:** \_\_\_\_\_ **Name (Please Print):** \_\_\_\_\_ **Signature:** \_\_\_\_\_



## Your Privacy: Our Policy

The provision of quality health care requires a relationship of trust and confidentiality. Consistent with our commitment to quality care, Chiro Clinic Moncton has developed a policy to protect patient privacy in compliance with current legislation.

### **Collection**

We will collect information that is necessary to properly treat you. Such necessary information may include;

- Full medical history, family medical history, contact details etc.
- Medicare/private health insurance details and billing/account details

The information will normally be collected directly from you. There may be an occasion when we will need to obtain information from other sources;

- Doctors (I.e. family physicians, chiropractors, and specialists etc)
- Other providers such as physiotherapists, occupational therapists, psychologists, pharmacists, massage therapists, dentists, hospital and day surgery units.
- Rehab practitioners (exercise physiologists, personal trainers, and kinesiologists)

### **Use & Disclosure**

With your consent, the practice staff will potentially use and disclose your information for:

- Account keeping and billing purposes for the management of our practice.
- Referral to another medical practitioner or health care provider.
- Clinic updates and newsletters via email.
- Quality assurance, practice accreditation and complaint handling.
- To prevent or lessen a serious threat to an individual's life, health or safety.
- Where legally required to do so, such as producing record to court, mandatory reporting of child abuse or the notification of diagnosis of certain communicable diseases.
- Contacting your next of kin or emergency contact to disclose sensitive information regarding your case in the event of an emergency, as deemed appropriate by the practitioners at this practice.
- Electronic practice management and health record keeping, where information shall be stored on servers located within Canada or abroad.

### **Consent**

I provide my consent for the staff and practitioners at Chiro Clinic Moncton to collect, use and disclose my personal information as outlined above. I understand that I may withdraw my consent as to use and disclosure of my personal information (except when legal obligations must be met).

**Date:** \_\_\_\_\_ **Name (Please Print):** \_\_\_\_\_ **Signature:** \_\_\_\_\_