Chiro Clinic
PHYSIO & MASSAGE

PHYSIOTHERAPY

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? ____

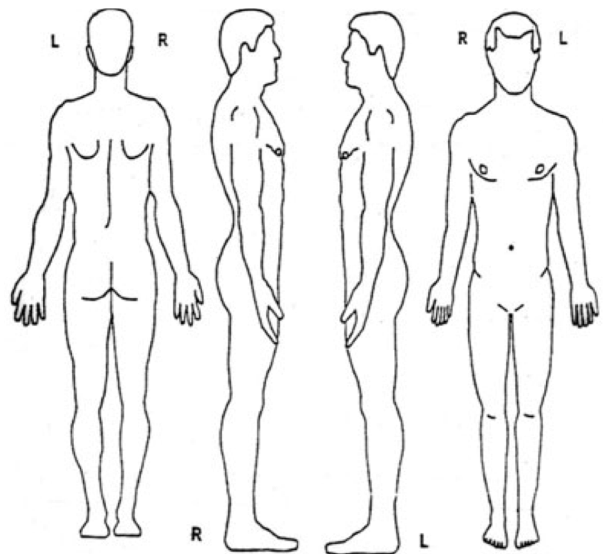
Family Doctor: _______________________________ Clinic: _____________________________________

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 <u>recently</u> 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

<u>Informed Consent to Physiotherapy Treatment</u>

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: ______________________

Cancellation And "No Show" Policy

We are trying to take care of each individual patient's needs during the patient's visit. However, in order to decrease waiting times, and as a courtesy to your fellow patients, we maintain a strict No Show/Cancellation Policy for all our patients.

If you are unable to keep your scheduled appointment, please *call the Clinic at least twenty-four (24) hours before your appointment* to reschedule or cancel in order to accommodate another patient on the waitlist.

A patient who does not arrive for their scheduled appointment without contacting our clinic at least twenty-four (24) hours in advance is considered a "no-show", and will be subject to paying 100% of the service fee, which must be paid in full before scheduling an additional appointment. We appreciate ample notice regarding reschedules and cancellations, so that we may offer available appointments to patients on our waitlist. Thank you for your understanding.

Please sign, indicating that you understand our cancellation and "no show" policy.

Date: ____________ Name (Please Print): _____________________ Signature: _____________________