Bolton
Physiotherapy
Clinic

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Bolton, ON

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Initial Intake Form

Today's Date

Welcome to Bolton Physiotherapy Clinic!

In order to serve you best, please take 10 minutes to fill out this form with all relevant information. If you require assistance, please see the receptionist. When finished, kindly return this form to the front desk.

PATIENT INFORMATION

Have you been here before? Yes No

If yes, when?

First Name:

DOB:

Last Name:

Gender:

Street Address:

City/ Town:

Province:

Post Code:

Home Phone:

Cell Phone:

Emergency Contact Information:

Full Name:

Relationship:

Contact Phone:

Family Physician:

Name:

Email:

Can we contact you via email/text? Yes No

Patient Photo ID Verified? Yes No

HEALTH HISTORY

Allergies:

Do you have a health history of any of the following? Please check all that apply.

Diabetes	Cancer	Chronic Cough	Epilepsy
Cardiac Disease	Anxiety or Depression	TB	High Blood Pressure
Liver or Kidney Disease	Smoker	Pacemaker or Similar	Blood Clots
Lung Disease	Osteoporosis	Shorness of Breath	Loss of Sensation
Multiple Sclerosis	Metallic Implants	CCHF	Hepatitis

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Asthma	Migraines	Bronchitish/Emphysema	Skin Conditions
Stroke/ Heart Attack	Athritis	Phlebitis	Currently Pregnant
Thyroid Disease	Allergies or Skin Irritation	Other	

Have you also recently experienced:

Double Vision/Dizziness	Difficult Speaking/Swallowing	Ringing In Ears	Changes in Bowels
Bladder Infection	Frequent Headaches	Changes In Appetite/Weight	

Current Area(s) Complaint:

MOTOR VEHICLE CASE INFORMATION

Date of Accident:

Have you reported your injuries to the insurance company? Yes No

Were you employed at the time of the accident? Yes No

Do you have legal representation? Yes No

If **YES**, please provide the name:

Do you have Extended Health Care benefit coverage? Yes No

If **YES**, please fill out the EXTENDED HEALTH COVERAGE section.

Automobile Insurance Company Information:

Name of Car Insurance Company

Policy/Group No: ID/Certificate:

Street Address: City/ Town:

Province: Post Code:

Adjuster's Last Name: Adjuster's First Name:

Adjuster's Phone No: Adjuster's Fax No:

Policy Holder same as Patient.

Policy Holder's Last Name: Policty Holder's First Name:

Policy Holder's DOB:

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EXTENDED HEALTH COVERAGE (PRIMARY)

Name of Insurance Company

Policy/Group No: | ID/Certificate:

Policy Holder's Last Name: | Policty Holder's First Name:

Policy Holder's DOB:

Direct billing **APPROVED** by patient. | Initial:

WSIB CASE INFORMATION

Date of Accident: | Claim No. (If you know):

Nurse Case Manager: | WSIB Adjudicator:

Employers Name: | Address:

Employers Phone No.: | Supervisors Name:

PRIVACY POLICY

- We collect, use, and disclose health information according to the Personal Health Information Privacy Act.
- I Agree to Bolton Physiotherapy Clinic collecting, using, and disclosing my health information to:
    - Other health practitioners of Bolton Physiotherapy Clinic.
    - My family physician or referring doctor as required.
    - My insurer, as required (including WSIB if applicable).

INFORMED CONSENT

- I understand that I need to express all of my health concerns (both current and past) to my therapist, including a contagious or infectious condition that I may have.
- I consent to an examination and treatment performed by a licensed Physiotherapist/ Athletic Therapist/ Massage therapist. The results will assist the therapist in determining the appropriate physical treatment to meet my specific needs and goals.
- I understand that my treatment with the therapist may involve the use of tele-rehab/medicine, physical and electrical modalities, acupuncture, stretching or mobilization of joints and tissue, and exercise programs aimed at mobility, strength and function.
- I understand that my treatment with the therapist may involve the use of a personal electronic device to provide education on my injury and a demonstration of stretching or mobilization of joints and tissues, and exercise programs aimed at mobility, strength and function.
- I understand that my therapist may contact my primary health care practitioner if there are any adverse effects during the tele-rehab or in-clinic session.I understand that discomfort may occur following treatment. The therapist will contact my physician should the presence of my symptoms represent any potential risks.
- I understand that it is my responsibility to contact my therapist should I experience unusual symptoms during in-clinic of or virtual sessions.

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- I understand that aspects of my treatment may be carried out by students under the supervision of the physiotherapist
- Bolton Physio practitioners provide a team approach, utilizing Physiotherapists, Athletic Therapists, Massage Therapists, and Strength and Conditioning coaches.
- I understand that if at any time I am not comfortable with and/or do not understand the purpose of any treatment procedure I will ask the therapist for further explanation/information. I understand that I may stop the assessment or treatment procedure at any time.

Initial:

TELE-REHABILITATION INFORMED CONSENT

- The provider is required to ensure that your location is safe and procedures have been put in place to ensure the availability of help if needed.
- It may be recommended that the session be conducted in the presence of another to enhance safety.
- The benefits of tele-rehabilitation consults include:
    - I will have access to medical providers without the costs and time associated with travel.
    - I will be able to stay close to home and in proximity to my family and caretakers.
    - Tele-rehabilitation will continue to grow and be widely utilized by my providers in the future.
    - It will remove accessibility barriers.
    - Will allow me to connect with my medical providers regardless of location.
- The risks of tele-rehabilitation consults include:
    - The connection may fail to work or may be disconnected during an encounter which might result in delays in care.
    - Your personal information will be kept secure and the provider will conduct the session from a private location. In very rare instances, security protocols could fail, causing a breach of privacy of personal and medical information – in these situations, providers will utilize any and all means necessary to correct the error as outlined in the policies related to PHIPA, Privacy, and Terms of Use and will notify me of the status of breach and attempts at correction.
    - Your insurance policy may not cover tele-rehabilitation services rendered and I may be required to pay for such services.

I, have read and understood, and had the opportunity to discuss the informed consent form.
(full name)

CANCELLATION POLICY

- If cancellation is neccessary, we require that you call at least **24 hours** in advance.
- Appointments are in high demand and your advanced notice will allow another patient access to therapy services.
- **No-shows** and **cancellations not abiding with the 24 hour policy result in a $50 fee** for Physiotherapy or the **full appointment fee for Massage Therapy.**
- Please note that **extended health coverage does NOT reimburse missed appointments.**

Initial:

PATIENT SIGNATURE

Full Name: Date:

Signature: