ReAlign Health
Matt Welsh Registered Physiotherapist

HEALTH HISTORY FORM

For Your Information:

An accurate health history is important to ensure that it is safe for you to receive a treatment. If your health status changes in the future, please let us now. All information gathered for this treatment is confidential except as required or allowed by law or to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____ Preferred Name (if any): _____

Address: _____ Today's Date: _____

City: _____ Postal Code: _____

Telephone Number (Home): _____ (Work): _____
(Cell):_____

E-mail Address: _____

How would you like to receive appointment reminders? ▫ Phone call ▫ Email

Date of Birth: _____/_____/_____
Month Day Year

Occupation: _____

Primary Care Physician: _____ Address: _____

Health History: please indicate conditions you are experiencing, or have experienced.

Respiratory
- ▫ chronic cough
- ▫ shortness of breath
- ▫ bronchitis
- ▫ asthma
- ▫ emphysema
- ▫ other _____

Cardiovascular
- ▫ high blood pressure
- ▫ low blood pressure
- ▫ CCHF
- ▫ heart attack
- ▫ phlebitis
- ▫ stroke/CVA
- ▫ pacemaker or similar device
- ▫ other

Family History
- ▫ arthritis
- ▫ cancer
- ▫ diabetes
- ▫ heart disease/stroke

Other Conditions
- ▫ diabetes: onset _____
- ▫ allergies _____
- ▫ cancer
- ▫ arthritis
- ▫ migraines &/or headaches
- ▫ loss of sensation
- ▫ vision problems
- ▫ vision loss
- ▫ ear problems
- ▫ hearing loss
- ▫ skin conditions
- ▫ hepatitis
- ▫ TB
- ▫ HIV
- ▫ other _____

Cigarette/Tobacco Consumption
- ▫ yes – amount _____/day
- ▫ no

Women
- ▫ pregnant:- due: _____

- ▫ neck
- ▫ low back
- ▫ mid back
- ▫ upper back
- ▫ shoulders
- ▫ arms
- ▫ hands
- ▫ hips
- ▫ legs
- ▫ knees
- ▫ feet
- ▫ other

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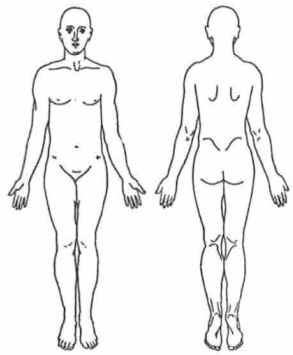
Rate your General Health



What is your **primary complaint?** (The reason you are coming to our clinic today)

_____

_____

_____

Please indicate (circle) which area is causing **the most** pain/difficulty for you.

Have you gone for any x-rays, ultrasounds, MRI's etc. for ***this injury/problem?*** YES / NO

If YES, where? _____ and approximately when?

_____

Present Involvement in Other Healthcare: YES (please specify) _____ NO

Current Medications:

_____

Surgeries (Nature/Date):

_____

Major Injuries (Nature/Date):

_____

Of Special Note (presence of internal pins, wires, artificial joints, special equipment, etc.):

_____

How did you learn about ReAlign Health?

□ Referral from doctor (doctor's name): _____

□ Friend/Patient (their name): _____

□ Other (please explain): _____

I hereby request and consent to the initial assessment provided by the physiotherapist. I will have the opportunity to discuss with the physiotherapist the nature, purpose, and types of therapies and treatments provided.

Signature: _____

Date: _____

ReAlign Health Physiotherapy Fees and Policies

Fees & Payment

Current fees for physiotherapy services are as follows:

Initial Physiotherapy Assessment $90.00

Physiotherapy Reassessment $75.00

Subsequent Physiotherapy Treatment -30 min $65.00

Subsequent Physiotherapy Treatment -45 min $90.00

Physiotherapy Shockwave Treatment $105.00

Patients for services are the responsibility of the patient and are to be paid at each visit.

I understand the fees and payment schedule policy _____ initials

Cancellation & No Show Policy

Out of respect for your therapist and your fellow patient, we appreciate 24 hour advance notice of cancellation. If you cancel your appointment with less than 24 hours notice, you will be charged the full visit fee. If you do not attend a scheduled appointment and do not call to cancel or reschedule ("no show"), you will be charged the full visit charge.

I understand the cancellation and no show policy _____initials

Consent for Communication/ Release of Information

It may be necessary for ReAlign Health to communicate with others involved in my care. By initialing below, I authorize ReAlign Health to communicate with the following parties with respect to my care:

Physician(s) _____ _____initials

Insurer(s) _____ _____initials

Other (please specify) _____ _____initials