REALIGN
LIVING HEALTHY

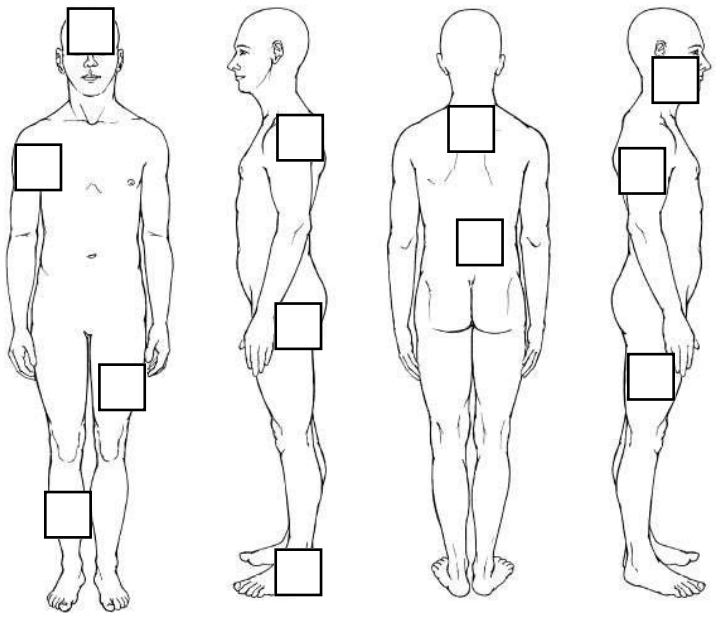
Physiotherapy
Health History and Entrance Form

A complete health history helps us ensure it is safe to provide you with a physiotherapy treatment; please let us know if your status changes so we can update your form. All information given to us is confidential.

Name _____ Email _____
We collect your email address to send you appointment reminders. Your email address will never be shared with a third party.
Home Phone _____ Cell Phone _____ Work Phone _____
Street _____ Unit _____ City _____ Prov. _____ Postal Code _____
Date of Birth (MM-DD-YY) _____ Age _____ Gender _____ Occupation _____
Emergency Contact Name _____ Emergency Contact Phone _____

Were you referred by another health care practitioner? If yes, who _____
Have you seen a physiotherapist before? Yes ☐No ☐ If yes, approximate date of last physio appointment _____
Do you see other healthcare practitioners? ☐ Chiro ☐ RMT ☐ Naturopath ☐ Osteopath ☐ Other _____
Current Medications and Conditions Treating _____
Previous Major Injuries/Operations (include dates) _____
Major Accidents _____
Of Special Note (presence of internal pins, wires, artificial joints, special equipment, etc.)

Please indicate areas you would like us to focus on and your primary area of complaint.



What is your primary complaint?

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Health History (please check all that apply to you)

Respiratory
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Emphysema

Joint/Muscle
- ☐ Jaw
- ☐ Neck
- ☐ Shoulders
- ☐ Arms
- ☐ Hands
- ☐ Upper back
- ☐ Mid back
- ☐ Low back
- ☐ Hips
- ☐ Knees
- ☐ Feet

Lifestyle (check all that apply)

Regular exercise	☐yes	☐no	☐mostly
Drink plenty of water	☐yes	☐no	☐mostly
8 hours of sleep nightly	☐yes	☐no	☐mostly
Good eating habits	☐yes	☐no	☐mostly

What is your general health?

_____

_____

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack/disease
- ☐ Congestive heart failure
- ☐ Stroke/aneurysm
- ☐ Pacemaker
- ☐ Varicose veins/phlebitis

Other
- ☐ Fever
- ☐ Arthritis OA/RA
- ☐ Headaches/migraines
- ☐ Loss of sensation/numbness/tingling
- ☐ Diabetes, onset _____
- ☐ Cancer, where _____
- ☐ Epilepsy
- ☐ Haemophilia
- ☐ Neuromuscular conditions
- ☐ Osteoporosis
- ☐ Mental illness
- ☐ Skin conditions
  what _____
- ☐ Artificial implants / pins / plates;
  where _____

EENT
- ☐ Vision loss/problems
- ☐ Dental problems
- ☐ Hearing loss/ear problems
- ☐ Hearing aid
- ☐ Sinus problems
- ☐ Allergies/hypersensitivity to
  type of reaction _____

Reproductive
- ☐ Pregnant, due _____

PHYSIOTHERAPY INFORMED CONSENT FORM

NOTE TO CLIENT We want your informed consent. This means that we want you to understand the services we hope to provide to you, the cost involved, and what we do with personal information we obtain about you. If you have a question about any of this, please ask.

Consent for Treatment: Treatment techniques recommended to you may include, but are not limited to, manual techniques, therapeutic exercise, electrotherapeutic modalities, acupuncture, as well as other techniques and procedures your treating healthcare practitioner determines may improve your function. Your healthcare practitioner will explain the benefits, side effects and potential complications of each chosen technique before use.

I hereby give my consent for ReAlign Health to conduct a thorough assessment and receive follow up treatments.
INITIAL _____

Consent for the cost of our Services:
I agree that I have been informed of the costs of the assessment and follow-up treatments/services provided to me. ReAlign Health may be able to bill these services directly to your insurance company or a third party responsible for the payment. In the following circumstances you will be responsible to pay at the time of service or product purchased:
• When you do not have any insurance that will cover the product or service
• When your insurance carrier sends payment directly to you or requires that you pay and submit your expenses
• When your coverage does not pay 100% or has been used up (you are responsible for the full remaining balance)

I agree to the information set out above regarding costs of services.
INITIAL _____

Consent for Personal Information
ReAlign Health collects, uses, discloses, retains and disposes of your personal information in compliance with federal and provincial privacy legislation and applicable college regulations. All staff members who come in contact with your personal information have signed a confidentiality form and have been trained in the appropriate use and protection of your information. We use and disclose your personal information in the following ways:
• To assess your health concerns, advise you of options and provide healthcare
• To communicate with other treating healthcare providers, including your physician
• To obtain diagnostic test results pertinent to the condition for which you are seeking treatment
• To allow us to efficiently follow-up for treatment, care and billing via phone, email, addressed mail and voicemail
• To establish and maintain contact with you
• To complete claims for insurance purposes
• To invoice for goods and services
• To collect unpaid accounts and process credit card payments
• To comply with the law
• To contact you from time to time during treatment and post-treatment about new services, changes to services, special offers, surveys, clinic updates and other opportunities, by phone, email or addressed mail and voicemail

I hereby consent to ReAlign Health collecting, using and disclosing personal information about me as set out above.
INITIAL _____

Cancellation Policy
24 hours advanced notice for any cancellations is required. ReAlign Health reserves the right to charge a missed appointment fee of $25.00.

I have read and understand the details outlined in this document.

Patient Name (Please Print) _____

Patient Signature (Legal Guardian) _____ Date_____

Physiotherapist Signature _____ Date_____