MacDonald-Bain Physiotherapy

Personal information

Last Name:_____First Name:_____ Middle Initial:_____ DOB (DD/MM/YYY):_____

Home Address: Street:_____ Apartment Number:_____

City:_____ Province:_____ Postal Code:_____

Email Address:_____ Primary Phone #:_____ Alternate Phone #:_____

Health Card Number:_____ Health Card Expiry (if applicable, DD/MM/YYYY):_____

Emergency Contact Person:_____Relationship:_____Primary Phone #:_____

☐ I would like to receive email reminders of my appointments

Referral

Family Doctor:_____ ☐ Nurse Practitioner (if applicable):_____

Referring Physician: ☐ Same as Family Doctor_____

Consent to the release of information

I _____ give my informed consent to the clinic to release information with respect to my care to the following:

1. Medical professionals: to disclose medical information to and obtain medical information from my physician, specialist or other treating therapist for the purpose of assessing or providing treatment.

☐Yes ☐No

2. Insurer: to disclose medical and/or other information with the relevant third party (indicate ICBC, extended health insurance, etc.)

☐Yes ☐No _____ _____ Initials

3. Lawyer: to disclose medical and/or other information to my lawyer

☐Yes ☐No _____ _____ Initials

4. Other: (indicate)

☐Yes ☐No _____ _____ Initials

I understand that my consent may be amended or revoked in whole or in part at any time by providing written notice to the clinic as outlined in the clinic's privacy policy.

_____	_____	_____
Patient name	Signature	Date

MacDonald-Bain Physiotherapy Patient Consent

Use of personal information

MacDonald-Bain Physiotherapy collects, uses, discloses, retains and disposes of your personal information in compliance with federal and provincial privacy legislation and applicable college regulations. All staff memebers 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. If you have any questions, please contact the MDB PT Privacy Officer at: (236) 979-0509 or via email at macdbphysio@gmail.com. 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, specialists or other treating therapists
- 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 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, clinic updates and other opportunities, by phone, email or addressed mail and voicemail

Financial Responsibility

You will be responsible to pay at the time of service. It is your responsibility to submit your receipts to your insurer for compensation.

Consent for Assessment & Treatment

I give my consent to undergo assessment and treatment. I have had the chance to discuss with my healthcare provider(s) the risks and benefits for my particular condition. My treatment may include, but not limited to: manual therapy, modalities (e.g. heat, ice, contrast bath, laser, ultrasound, interferential current (IFC), electrical muscle stimulation, TENS, acupuncture, dry needling, intramuscular stimulation, cupping, spinal manipulation) and active exercise.

Your physiotherapist will explain the benefits, side effects and potential complications of each chosen technique before use. Any questions or concerns you may have about any recommended treatment must be shared with your physiotherapist immediately so she can explain the treatment rational or modify the treatment program appropriately. If at any time you choose not to participate in the prescribed course of treatment please inform your physiotherapist immediately.
I understand that results are not guaranteed and that I may withdraw this consent at any time.

I give my voluntary informed consent for the entire course of assessment and treatment for my present condition commencing on the date below. I understand that I may ask questions at any time and that my consent may be withdrawn in writing or verbally at any time.

Name of Patient:

_____

Signature of Patient (or Guardian):

_____

Patient Date of Birth: (DD/MM/YYYY):

_____

Date of Signature (DD/MM/YYYY):

_____

_____

Physiotherapist signature - Consent Confirmed after Assessment

Cancellation Policy

We appreciate a minimum of 24 hours advance notice for any cancellations and reserve the right to charge the full treatment fee if not adhered to.

Name of Patient:

_____

Signature of Patient (or Guardian):

_____

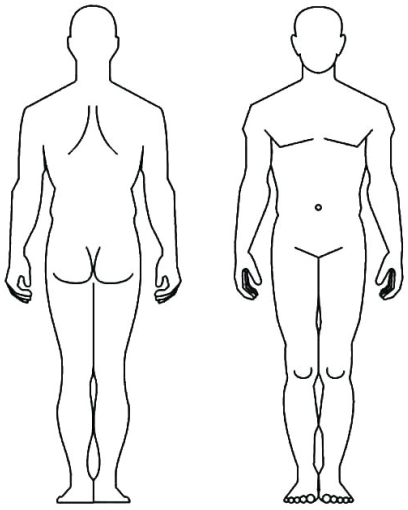
Date of Signature (DD/MM/YYYY):

_____

MACDONALD-BAIN physiotherapy

Date _____
Patient name _____
Occupation _____

Please circle the area of your symptoms



How would you rate your pain out of 10?
(0 = no pain, 10 = pain requiring hospitalization)

Breifly describe your symptoms or condition

Would you describe your pain as (please circle):

constant intermittent worsening getting better same

What makes it worse?

What makes it better?

Do you experience any pins and needles, burning, or numbness?
Where?

Have you had any previous related injuries or symptoms in this same area?

Have you had any other treatment for this injury? e.g. massage, acupunture, physiotherapy, chiropractic, etc.?

Current medications (feel free to provide a copy of your medication list instead)

☐ Night pain ☐ Metal allergies ☐ Changes in body weight ☐ Changes to your continence bowel/bladder

☐ Are you using blood thinners?

Past/present medical history

Please list any previous surgical procedures and any details/hardware (ie. prosthesis, wires internal pins, fixators, breast or other implants)

Cardiovascular

☐ High/low blood pressure
☐ Chronic congestive heart failure
☐ Angina
☐ Heart attack
☐ Stroke/CVA
☐ Pacemaker/internal defibrillator
☐ Hemophilia
☐ Arteriosclerosis
☐ Bleeding disorder
☐ Varicose veins
☐ Phlebitis
☐ Poor circulation

Respiratory

☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Chronic cough
☐ Shortness of breath
☐ Difficut breathing
☐ Smoking
☐ Other:

Head and Neck

☐ History of headaches/migraines
☐ Vision loss or changes
☐ Hearing loss/ear conditions/hearing aid
☐ Dizziness or double vision, vertigo
☐ Sinus problems
☐ Jaw/TMJ pain

Infectious conditions

☐ Hepatitis
☐ Tuberculosis (TB)
☐ HIV/AIDS
☐ Skin conditions
☐ Any other:_____

Women/pelvic health

Are you currently pregnant?
Yes No
If yes, due date_____
Number of prior pregnancies_____

Other conditions

☐ Diabetes: onset and type_____
☐ Epilepsy/seizures
☐ History of cancer: onset/type/current state _____
_____
☐ Anxiety
☐ Depression
☐ Vestibular/balance conditions
☐ Kidney problems
☐ Insomnia/sleeping problems
☐ Fibromyalgia
☐ Anemia
☐ Gout
☐ Thyroid problems
☐ Fainting
☐ Numbness/tingling
☐ Digestive conditions
☐ Skin conditions
☐ Allergies/hypersensitivities _____
_____

Muscle and joints *Please indicate areas that you have current or past history with*

☐ Neck	R L	☐ Wrist	R L	☐ Artificial joints/pins/wires/screws
☐ Upper back	R L	☐ Hand	R L	
☐ Mid back	R L	☐ Hip	R L	Location(s)_____
☐ Lower back	R L	☐ Leg	R L	
☐ Shoulders	R L	☐ Knee	R L	☐ Osteoarthritis
☐ Elbows	R L	☐ Ankle	R L	☐ Rheumatoid arthritis
☐ Arm	R L	☐ Foot	R L	☐ Other rheumatic conditions/autoimmune disease:
				_____

Car accident(s):
Date(s):_____
_____

Bone health

☐ Osteoporosis/Osteopenia
Date of last bone density scan_____

☐ History of fractures
Date(s)_____
Location_____

Other

Sports and activities: _____

_____