Crowchild Physiotherapy Massage, Chiropractic
at Brentwood Village Centre

PHYSIOTHERAPY–Patient Intake Form

Personal

Please read & fill in all information in details

☐ All the information in this section has not changed since my last visit. Please proceed to the Referral Section below.

First Name:_____ **Last Name:**_____ **Date of Birth:**_____
(Mm/dd/yyyy)

Current Address:_____

City:_____ **Province:**_____ **Postal Code:**_____

Email Address: _____ **Cell Phone:**_____

Home Phone:_____ **Work Phone (optional):**_____

Health Card No _____ **Gender: Male / Female**

_____

Emergency Contact Person **Relationship** **Phone**

Physician Details:

Family Physician
Full Name: _____ Clinic Name: _____

Clinic Number _____

Incident Physician
Full Name: _____ Clinic Name: _____

Clinic Number _____

Referral:

How did you hear about us: ☐ Brentwood Community, ☐ Google, ☐ Physician _____, ☐ Newspaper/Magazine
☐ Friends/Relatives(full name) _____, ☐ Other _____

For Prenatal Clients Only - Please Fill in What Applies To You:

☐I may be pregnant ☐ I am pregnant
☐ This is my 1st, 2nd or _____ Pregnancy
☐ I am _____ (number) week(s) in my _____ (1st, 2nd, 3rd) trimester

Anything else you would like your therapist to know? _____
☐**Please read the Consent for Prenatal Physiotherapy**

For MVA only Have you completed Accidents Benefits Package (AB1 & AB2)? ☐Yes ☐No
For WCB only Have you completed WCB Intake form ☐Yes ☐No
For Private only Have you completed Direct Electronic Submission Form ☐Yes ☐No

Next Page

Consent

Crowchild Physiotherapy Massage, Chiropractic at Brentwood Village Centre

PHYSIOTHERAPY–Patient Intake Form

Consent for Assessment and Treatment:

Assessing physiotherapist will collect all the necessary information pertaining to your injuries for assessment purpose. Explain the treatment techniques that may include Manual Therapy to Joints and Muscles, use of therapeutic electrical modalities, Acupuncture (use of needles) if needed, Exercise therapy. Your Physiotherapist will also explain the benefits and side effects if any during the treatment period. It is **your responsibility** to inform the treating therapist if you **DO NOT** understand assessment and treatment plan. At any time if you choose not to continue to participate in the treatment plan you must inform the treating therapist immediately.

☐ I **UNDERSTAND**, & choose to continue with assessment & treatment

Patient/Parent/Guardian Signature: _____ **Date: _____**
If you are under the age of 18, Parent/Guardian must sign

Representative Witness Signature: _____ Date: _____

Consent for Prenatal Physiotherapy

_____(sign), I authorize *Crowchild Physiotherapy* to administer physiotherapy to me during my pregnancy. I understand that *Crowchild Physiotherapy* strongly encourages me to communicate with my physician about the potential benefits and risks.

Medical Records Consent

Release of Medical Record:

I authorize *Crowchild Physiotherapy* to **Release or Request** any information from **Physicians**, **Diagnostic Centers**, **Insurance Companies, Employers, and Law Firms** with respect to my care.

Patient/Parent/Guardian Signature: _____ **Date: _____**
If you are under the age of 18, Parent/Guardian must sign

Billing & Payment

Payment for Service Acknowledgement

I authorize *Crowchild Physiotherapy* to submit claims on **my behalf** to my insurance company and I am responsible to **pay any co-payment or any outstanding balance** for my physiotherapy & massage services at each time of the appointment upon arrival. In the event my insurance company denies the payment for any reason, **I would be solely responsible to pay for my physiotherapy & Massage services. OR**
If the client **does not** carry any insurance coverage, then Client is **fully responsible** to pay the complete fee amount for his/her Physiotherapy/ Massage services at each time of the appointment upon arrival.

Patient/Parent/Guardian Signature: _____ **Date: _____**
If you are under the age of 18, Parent/Guardian must sign

Cancellation Policy

Please provide **24 HOURS** cancellation notice for all **Physiotherapy / Massage** appointments. We reserve the right to charge the cancellation fee for all cancelled or missed appointments without **24 Hours'** notice.

Please note that your Insurance is not responsible to cover the cost of the cancellation fees.

PHYSIOTHERAPY CANCELLATION FEE: Per Session $30

I have read, understood and agreed to the cancellation policy as stated above.

Last Page

Patient/Parent/Guardian Signature: _____

DIRECT ELECTRONIC CLAIM SUBMISSION AUTHORIZATION

Patient Name: _____Date of Birth (MM/DD/YYYY):_____

Name of the **Primary** Insurance Company: _____

Primary Policy Holder Name: _____ Date of Birth (MM/DD/YYYY):_____

Policy ID/Claim #: _____Group/ ID: _____

Do you have any other/secondary Extended Health Benefit? _____

Name of the **Secondary** Insurance Company: _____

Secondary Policy Holder Name: _____ Date of Birth (MM/DD/YYYY):_____

Policy ID/Claim #: _____Group ID: _____

Assignment of Benefits Needed? Yes / No

Coverage Period Start: _____ End: _____

***Physiotherapy Coverage*:**
Max Limit: $_____Percentage covered each visit: _____ Deductibles: _____

Does your Insurance required a Doctor's referral for Physiotherapy e-Claims? Yes/No

- If Yes, Physicians Name_____ Date of Referral_____

Massage Coverage:
Max amount Limit: $_____Percentage covered each visit: _____ Deductibles: _____

Does your Insurance required a Doctor's referral for Physiotherapy e-Claims? Yes/No

- If Yes, Physicians Name_____ Date of Referral_____

Custom Foot Orthotics:
Max amount Limit: $_____Percentage covered each Year: _____ Deductibles: _____

Doctor's referral provided for Custom foot Orthotics? Yes / No

If Yes, Physicians Name_____ Date of Referral_____

Did you apply for Custom foot orthotics earlier to your Insurance? Yes/No

- If Yes, Please provide the date of Service_____

CONSENT

- **I hereby certify that Crowchild Physiotherapy has been authorized to submit claims on my behalf to my Insurance Company and the information contained in the claims is complete and accurate.**
- **I am responsible to pay the co-payment, if applicable, at the time of each appointment.**
- **I understand that I am fully responsible to make full payment, if my insurance company denies my claim.**

Signature: _____ **Date**: _____

Medical Authorization Permission

Attention: Medical Records Dept.
Clinic/hospital/physician/law firm/employer

Date: (mm/dd/year) _____

Patient's name:

AHS #:

Date of birth:

Date of Injury Occurred:

I, _____, hereby authorize Crowchild Physiotherapy to Release and Request copies of any or all information from Physicians, Diagnostic Centers, Insurance Companies, Employers, and Law Firms with respect to my care.

Requesting /Releasing: Related to injury due to: ☐ MVA ☐ WCB ☐ General pain/injury

Diagnostic Report: ☐ X-Ray ☐ Ultrasound ☐ MRI ☐ Other:_____

Diagnostic report date: _____Body Part(s):_____
(If available)

Reports: ☐ MVA Forms ☐ WCB ☐ Treatment Charting Notes

OTHER:

_____

_____

*** This authority shall continue until withdrawn, by me, in writing. ***

Patient signature: _____ Date: _____

Crowchild Physiotherapy Massage, Chiropractic
at Brentwood Village Centre

SHIFT CONCUSSION MANAGEMENT PROGRAM LEVEL I PROVIDER

Confidential Patient Information Form

Please complete the following questionnaire as fully and carefully as possible. Your answers will help us to process your file, determine the nature of your injury, and decide how best to assist you. This information will remain strictly confidential.

PERSONAL INFORMATION

Name:_____ Date of Birth: ____/____/_____ (dd/mm/yyyy) Age:_____ M/F

Address:_____ City:_____ Postal Code: _____

Telephone: (home) _____ (work and/or cell) _____

Email: _____

Emergency Contact: (name/relation) _____ (Tel) _____

Current Occupation: _____

Name of Medical Doctor: _____ (Tel) _____

If Sport Related Injury:

Sport:_____ Team: _____

How were you referred to the Shift Concussion Management Program? _____

INJURY/DESCRIPTION OF COMPLAINT

Give a Brief Description of your Injury/Complaint (Include how it was sustained):

_____

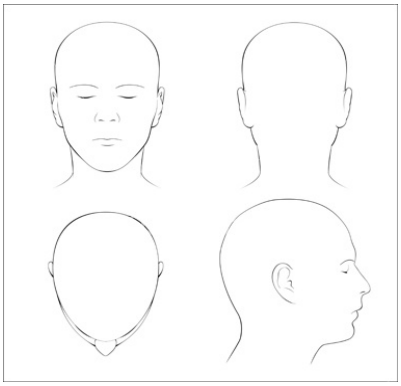
_____

_____

Date of Injury/Symptom Onset: _____

For Head/Neck Pain:

On the drawings to the right, please mark painful areas with symbols given:



X	Sharp & Stabbing	△ Burning	Pins & Needles
S	Dull Ache	○ Numb	= Stiff & Tight
☆	Pressure	# Throbbing	

Rate the following by circling a number:

Level of pain **now:** None 0 1 2 3 4 5 6 7 8 9 10 Worst ever felt

Level of pain **at its worst:** None 0 1 2 3 4 5 6 7 8 9 10 Worst ever felt

Is your pain: ☐ constant ☐ intermittent/random ☐ activity dependent ☐ not sure

POST CONCUSSION SYMPTOM SCALE

Please Indicate how you are feeling based on the **last 2 days:**

0 = NONE; 1-2 = Mild; 3-4 = Moderate; 5-6 = Severe

Headache	0 1 2 3 4 5 6	Sensitivity to Noise	0 1 2 3 4 5 6
Nausea	0 1 2 3 4 5 6	Irritability	0 1 2 3 4 5 6
Vomiting	0 1 2 3 4 5 6	Sadness	0 1 2 3 4 5 6
Balance Problems	0 1 2 3 4 5 6	Nervousness	0 1 2 3 4 5 6
Dizziness	0 1 2 3 4 5 6	Feeling more Emotional	0 1 2 3 4 5 6
Fatigue	0 1 2 3 4 5 6	Numbness or Tingling	0 1 2 3 4 5 6
Trouble Falling Asleep	0 1 2 3 4 5 6	Feeling Slowed Down	0 1 2 3 4 5 6
Sleeping more than Usual	0 1 2 3 4 5 6	Feeling Mentally "Foggy"	0 1 2 3 4 5 6
Sleeping less than Usual	0 1 2 3 4 5 6	Difficulty Concentrating	0 1 2 3 4 5 6
Drowsiness	0 1 2 3 4 5 6	Difficulty Remembering	0 1 2 3 4 5 6
Sensitivity to Light	0 1 2 3 4 5 6	Visual Problems	0 1 2 3 4 5 6

Overall, is your pain getting ☐ better? ☐ worse? ☐ staying relatively constant?

Have you sought medical evaluation for your current complaint before now? ☐ Yes ☐ No

If yes, indicate type: ☐ Family MD ☐ Sport MD ☐ Emerge MD ☐ Walk-in MD ☐ Other_____

Have you had any imaging for your current complaint (Xray, CT, MRI)? ☐ Yes ☐ No

Please list any medications, or supplements (e.g. vitamins) you are currently taking (including over-the-counter):

_____

Do any of the conditions below apply to you? ☐ None

☐ ADHD ☐ Depression ☐ Migraine ☐ Learning Disability ☐ Sleep Disorder ☐ Anxiety

Are you currently experiencing any ongoing medical conditions not listed?_____

Have you had a routine eye exam in the last year? ☐ No ☐ Yes

PAST HEALTH HISTORY

Have you sustained any previous Concussions? ☐ No ☐ Yes If yes, indicate when they occurred and length of recovery:

_____

_____
_____
_____

Please indicate any previous **surgeries, hospitalizations, fractures, or traumas (other than concussion)** (include year):

_____
_____
_____

FAMILY HEALTH HISTORY

Have you or anyone in your immediate family had any of the following (please check those that apply):

☐Heart disease ☐High blood pressure ☐Cancer ☐Diabetes ☐Stroke ☐Other Disease _____