CONCEPT OF MOVEMENT
Physiotherapy and Performance Wellness

PATIENT INTAKE FORM

Patient Name: _____
Birth Date (D/M/Y): ____/___/_____ Gender: ☐ Female ☐ Male
Email (for appointment reminders & home exercises): _____
Do we have permission to send you e-blasts? ☐ Yes ☐ No
Address: _____ City:_____
Postal code: _____ Phone (Home): _____
Phone (Cell): _____
Occupation: _____

Emergency Contact _____ Phone: _____
Relationship: _____

GUARDIAN (Please complete if under 16 years of age):
Name: _____
Birth Date (D/M/Y): ____/____/_____
Guardian Signature: _____ Date: _____

PRIMARY CARE PHYSICIAN:
Physician name: _____
Phone: _____
Address:_____
Do we have permission to send updates and reports to your family doctor? ☐ Yes ☐ No

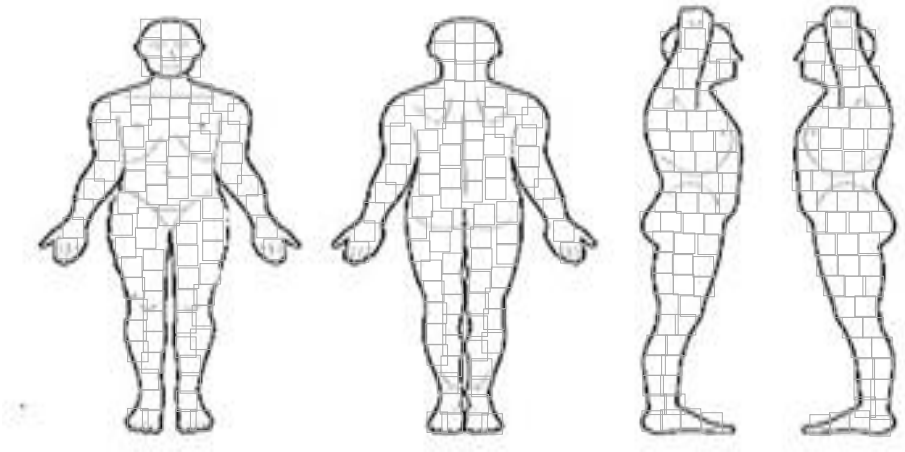
Please list other people you may be currently seeing or may have seen regarding your condition (including trainers):
_____
What is 1 thing you liked, and 1 thing you did not like about your previous healthcare professional? (If applicable) _____
Is your general health good? ☐ Yes ☐ No
IF no, what problems do you have? _____

CONFIDENTIAL HEALTH SCREENING QUESTIONNAIRE

ADDRESSING WHAT BROUGHT YOU TO THE CLINIC:
1. What is your main symptom/problem? _____
2. When did your symptoms begin? _____
3. Have you had this problem before? ☐ Yes ☐ No
4. Is the problem there – ☐ constantly ☐ comes & goes ☐ with use ☐ at rest?
5. Is the problem getting - ☐ worse ☐ no change ☐ better?
6. What makes it worse? _____
7. What makes it better? _____
8. How does it feel? ☐ Burning ☐ Sharp ☐ Shooting ☐ Dull ☐ Stiff ☐ Aching ☐ Tingling ☐ Throbbing ☐ Swelling ☐ Other: _____
9. How would you rate the severity of your pain (0 = no pain, 10 = severe pain)? _____
10. Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation?

11. What tests have you had for this condition? ☐ Ultrasound ☐ X – Ray ☐ MRI ☐ CT Scan
12. Have you received any treatment for this condition? ☐ Chiropractic ☐ Physiotherapy ☐ Massage Therapy ☐ Acupuncture ☐ Surgery (Date D/M/Y: _____) ☐ Other: _____

INDICATE AREA OF THE BODY PAIN BY PLACING AN "X' ON THE DIAGRAM



PATIENT HEALTH QUESTIONNAIRE:

Cardiovascular - Past ☐ Present ☐
Respiratory - Past ☐ Present ☐
High/Low blood pressure ☐
Chronic cough ☐
Chronic congestive heart failure ☐
Shortness of breath ☐
Heart attack ☐
Bronchitis ☐
Phlebitis/varicose veins ☐
Asthma ☐
Stroke/CVA ☐
Emphysema ☐
Pacemaker or similar device ☐
Heart disease Head and Neck ☐
Heart palpitations ☐
Diabetes Infections ☐
Thyroid problems ☐
Hepatitis ☐
Cancer ☐
Skin conditions ☐
Kidney problems ☐
TB ☐
Depression ☐
HIV Arthritis: ☐
Psoriatic ☐
Herpes ☐
Gout ☐

Dizziness or blackouts ☐
Repeated infections ☐
Weakness in arms or legs ☐
MRSA ☐
Coordination problems ☐
VRE ☐
Loss of balance ☐
Difficulty walking Allergies: ☐
Pain at night Loss in appetite ☐
Nausea/vomiting Surgeries: ☐
Urinary problems ☐
Weight Gain/ Weight Loss ☐
Headaches ☐
Chest pains ☐
Migraines ☐
Vision Problems ☐
Diabetes ☐
Peripheral Neuropathy ☐
Vision loss ☐
Broken bones/fractures ☐
Ear problems ☐
Osteoporosis ☐
Hearing loss ☐
Epilepsy ☐
Difficulty swallowing ☐
Bowel problems ☐
Other Conditions ☐

HAVE YOU EVER:
Had an accident (car, fall, sport, other)?
☐ No ☐ Yes, please describe:

_____
Had an operation?
☐ No ☐ Yes, please describe: _____
Had a fracture?
☐ No ☐ Yes, please describe: _____
Been hospitalized?
☐ No ☐ Yes, please describe: _____

Do you Smoke? ☐ Yes ☐ No
Do you exercise beyond normal activities and chores? ☐ Yes ☐ No
Do you have menstrual/menopausal problems? ☐ Yes ☐ No
Do you have a family history of: ☐ Heart disease ☐ Psychological Conditions ☐ Cancer ☐ Diabetes ☐ Hypertension ☐ Arthritis ☐ Stroke ☐ Osteoporosis
Have you ever taken steroids? E.g. Prednisone, cortisone ☐ Yes ☐ No
Are you currently taking any prescription or over the counter medications? ☐ Yes ☐ No
If yes please specify: _____
Allergies:_____ Are you pregnant?: ☐ No ☐ Yes How many weeks? _____
Do you have a history of depression? ☐ Yes ☐ No
During the last month:
a) Have you often been bothered by feeling down, depressed, or hopeless? ☐ Yes ☐ No
b) Have you often been bothered by little interest or pleasure in doing things? ☐ Yes ☐ No

I certify that all the above personal health information, on page one and two, is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition in the future.

Print Patient Name:_____

Signature:_____

Date (D/M/Y) _____/_____/_____

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CONSENT FOR ASSESSMENT

I, _____ of my own free will consent to be assessed for the following complaints:

_____

I have accurately completed my health history to the best of my ability. I have indicated ALL of my known medical conditions and Medications (prescribed and over the counter). I take it upon myself to keep the physiotherapist updated on my physical health. I understand my health history and any conversation in the treatment. I acknowledge that the purpose of this assessment is to determine/ diagnosis my symptoms through discussion and testing and that I may receive physiotherapy treatment as a part of the assessment.

I will advise my Physiotherapist if I am/have: HIGH OR LOW BLOOD PRESSURE, HYPERMOBILE. Please note that the assessment may cause your symptoms to flare up and it may be necessary to expose some of your body parts for proper evaluation. During my assessment, the Physiotherapist will discuss the benefits and risks of the treatment they are suggesting. They will discuss any side effects that may occur as a result of proposed treatment. They will also discuss alternate courses of action for my condition which may include a supervised exercise component which is designed to progress you towards independence, as well as the consequences of not having the proposed treatment. I may withdraw my consent for assessment at any time. By signing this document, I acknowledge that I have read and understand the above statements and agree to my assessment based on this information. I therefore provide my informed consent for an assessment.

_____ _____

Client Name [Please Print] Client Signature

_____ _____

Date Guardian Signature (if under 18)

AGREEMENT OF RELEASE AND WAIVER OF LIABILITY

This form covers all services offered by Concept of Movement Ltd. Please fill out the following, being sure to read each paragraph. I, _____, hereby agree to the following:

- That I am participating in physiotherapy, athletic training, injury prevention training, strength and conditioning training or other services offered by Concept of Movement Ltd., during which I receive information and instruction about healthy and safe practice. I recognize that these therapies, sessions and/or classes may require physical exertion, which may be strenuous and could result in physical injury, and I am fully aware of the risks and hazards involved.
- I understand that it is my responsibility to consult with a physician prior to and regarding my participation in classes, workshops, and therapies.
- I represent and warrant that I am physically fit and I have no medical condition that would prevent my full participation in these therapies, sessions and/or classes.
- I agree to assume full responsibility for any risks, injuries or damages, known or unknown, which I might incur as a result of participating.
- I agree to inform my movement coach and supervising therapist of any physical limitations, physical discomforts and/or injuries before or during classes, and I take full responsibility for nondisclosure.
- In further consideration of being permitted to participate in therapies, sessions and/or classes, I knowingly, voluntarily and expressly waive any claim I may have against Concept of Movement Ltd. for injury or damages that I may sustain as a result of participating.
- I have read the above release and waiver of liability and fully understand its contents. I agree to its contents and I voluntarily agree to the terms and conditions stated above.

RESPONSIBILITY FOR PAYMENT OF TREATMENT

IF THIS IS A WSIB CLAIM OR MOTOR VEHICLE ACCIDENT CLAIM – PLEASE CALL BEFORE COMPLETING FORMS (705) 728-9333. WE ARE NOT AN OHIP CLINIC.

Concept of Movement Ltd. is a private health care facility. We believe in offering one-on-one treatment with experienced and professionally qualified therapists. It is your responsibility to keep track of your plan specifics, submissions for reimbursement and educate yourself regarding your extended health insurance coverage.

APPOINTMENT CANCELLATION POLICY

COMPHYSIO+ is committed to providing exceptional care to all our patients. Unfortunately, when one patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at (705) 728-9333 by 2:00 pm on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 pm on Saturday.

If prior notification is not given, you will be automatically charged for the session.

Please sign below to consent to these terms.

_____ _____

Client Name [Please Print] Client Signature

_____

Date

INDIVIDUAL CONSENT FORM TO DISCLOSE PERSONAL INFORMATION TO A DESIGNATED THIRD PARTY

Concept of Movement believes that it is important to establish and maintain clear lines of communication with all parties involved in the successful rehabilitation of your injury. As a result, information relating to your treatment progression and treatment plans may be shared with your physician, case manager, employer and/or third-party payer. I have reviewed the Privacy Policy (back of page) about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I have about the Privacy Policies and they have been answered to my satisfaction.
I, _____(please print your name) hereby authorize, and understand the Policies and Procedures for personal information from Concept of Movement Ltd. to release of my personal and/or progression notes, or any other medical information to my: *(please fill in the appropriate names)*

Family Physician: _____
Insurance Company: _____
Lawyer Medical Specialist: _____
Other: _____

Or, I accept responsibility for ensuring that my report is taken to the appropriate party/appointment.

Print Name: _____
Signature_____
Date of Birth _____
Date _____