thrive PHYSIO

237 Locke St. S.
Hamilton, ON L8P 1V4
Ph: 905 524 0000
Fax: 905 577 0000
info@thrivephysio.com

Patient Intake Form

Name (Last, First):				*Date of birth (DD/MM/YY):*
Address		*City*		*Postal Code*
Phone (home)	*Phone (cell)*		*Phone (work)*	
Email:		*Family Doctor:*		
Emergency contact (name, phone & relationship to you):				

How did you hear about us?

☐ Return Patient ☐ Location/Street Sign ☐ Local businesses _________________

☐ Website ☐ Facebook/Twitter ☐ Family/friend referral _________________

☐ Google ☐ Family Doctor ☐ Other __________________

Thrive Physio Policies:

1. Please provide 24 hours notice of cancellation for your appointment. A fee will be charged to your account if you do not show up for your appointment or if you choose to cancel within 24 hours of your appointment time.
2. Payments for services are the responsibility of the patient and are to be paid at each visit via cash, debit, or credit card. If a third party payer (EHB, WSIB, MVA) denies or partially pays the amount billed, you are responsible for paying the outstanding amount.

I understand, and agree with, the criteria listed under Thrive Physio policies

___________________________________ _____________________
Signature of patient Date

Consent to communicate via email

Can we email your appointment reminders to you 1 day prior to your appointment? ☐ Yes ☐ No

I authorize Thrive Physio to contact me via email for appointment reminders and clinic information

___________________________________ _____________________
Signature of patient Date

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Consent for Assessment and Treatment

Assessment and treatment at Thrive Physio may include, but is not limited to: manual therapy techniques, spinal manipulation, electrotherapeutic modalities, acupuncture, registered massage therapy, and exercise. It is the policy of Thrive Physio to ensure that each patient is educated about the benefits, side effects, and potential complications of each of the treatment modalities used by our therapists to decrease symptoms, and improve function, before use.

If you have any questions or concerns about any of your recommended treatments, you must inform your healthcare provider immediately, so they can explain the treatment rationale and/or modify your program accordingly. If at any time you choose not to participate in any type of treatment, you must inform your healthcare provider immediately.

I understand and agree with the above criteria and, in compliance with the "Consent to Treatment Act" Bill 109, voluntarily consent to participate in an assessment and treatment program for my stated injury(ies) at Thrive Physio.

I understand that my consent may be withdrawn at any time during my treatment after informing my healthcare provider at Thrive Physio, and that I may stop or alter my physiotherapy/massage therapy treatment at any time.

______________________________ ____________________
Patient Name (print) Date of birth (DD/MM/YY)

______________________________ ____________________
Signature of patient Date

Comments: ____

Release of Medical Information

Your privacy is of the utmost importance to us. The information collected in this intake form will assist us in treating you safely. All information provided will be kept confidential unless by the request of the patient to distribute, or required by law. Your written permission is required in order to release any of your treatment details, and for us to obtain information, from your previous/current health care providers.

I authorize Thrive Physio to release my physiotherapy/massage therapy records to, and to obtain medical /health records from all practitioners concerned with my care.

______________________________ ____________________
Signature of patient Date

Comments: ____

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Health History Form

An accurate health history is important to ensure that it is safe for you to receive therapy. If your health status changes in the future, please let us know. All information gathered for this treatment is confidential except as required or allowed by law.

Patient Name: ______________________________ DOB: _________________________

CARDIOVASCULAR

□ High blood pressure

□ Low blood pressure

□ Chronic congestive heart failure

□ Heart attack

□ Stroke/CVA

□ Chest pain

□ Phlebitis/varicose veins

□ Heart disease

□ Pacemaker or similar device(s)

RESPIRATORY

□ Chronic cough

□ Shortness of breath

□ Bronchitis

□ Asthma

□ Emphysema

COMMUNICABLE DISEASES

□ Hepatitis

□ Skin conditions

□ TB

□ HIV/AIDS

□ Any other communicable diseases or haemophilia?

If so, please describe: ___________

____

OTHER CONDITIONS

□ Osteoporosis/Osteopenia

□ Fractures: ______________________

□ Arthritis - Onset/type:

____

□ Diabetes Onset/type:

____

□ Epilepsy

□ Depression

□ Cancer - Onset/type/current state:

____

____

□ Allergies/hypersensitivity?

□ Digestive Conditions

□ Organ dysfunction

□ Other: ______________________

Is there a family history of any of the above conditions? if so, please describe:

____

____

□ Loss of sensation (area)

____

□ Dizziness

□ Urinary/bowel incontinence

HEAD/NECK

□ History of headaches

□ History of migraines/ new onset?

□ Vision loss/changes

□ Dizziness/Double vision

□ Hearing loss/ear condition(s)

PELVIC HEALTH

□ Pregnant, Due date: ____________

# of prior pregnancies: _____________

OF SPECIAL NOTE:

Please list any previous surgical procedures and any details/hardware (Ie/ prosthesis, wires, internal pins/fixators):

____

____

____

Primary complaint/injury at this time:

____

____

____

Current Medication(s) (please feel free to provide a copy of any medication lists instead):

1. _______________________ 2. _______________________ 3. _______________________ 4. _______________________