PATIENT INTAKE FORM

Name:		
Street Address:		
City:	Postal Code:	
Phone: (home)	(Cell)	(Work)
Email Address:		
Would you like to receive York Rehab's email newsletter which includes information regarding clinic exercise class schedules, workshops, special promotions, and community health news and/or health & lifestyle advice. ☐ Yes ☐ No		
Gender *(circle)*: M F	Date of Birth:	
Family Doctor:		
Referring Doctor:		
How did you discover this clinic? *(please circle)*	Family Doctor | Specialist | Friend/Family | Yellow Pages | Website | Facebook | Other *(please specify)*:	

Extended Health Insurance:

Insurance company:
Policy Number:
ID Number:
Policy Holder Name: ☐ Same as above ☐ Other:
If the patient is not the policy holder, please indicate relationship: Spouse Child
Policy Holder's Date of Birth:

Motor Vehicle Accident Patients – ONLY (*Please fill out this section*)

Insurance Company *(Branch Office if applicable)*	
Address	
Telephone Number	
Fax Number	
Adjuster's Name	
Date of Accident	
Policy Number	
Claim Number	
Name of Policy Holder *(If different from claimant)*	

WSIB – Workers Compensation Patients – ONLY (*Please fill out this section*)

Employer	
Employer's Address	
Claim Number	
S.I.N. Number	
OHIP Number	
Date of Injury	

If you require assistance completing this form, please print a copy and bring it to your first appointment.

MEDICAL INFORMATION

Date of Surgery/Injury:

_____

Have x-rays been taken?
YES NO
Where?_____

GENERAL INFORMATION

Age: _____

Occupation: _____

Are you… Working?
Off Work?
Retired?

To help us better understand the stresses/strains on your injury, please answer the following:

Right or Left Handed?
R L
Family Status/Who lives with you?

_____
_____

Children and Ages

_____
_____

Sports/Hobbies

_____
_____

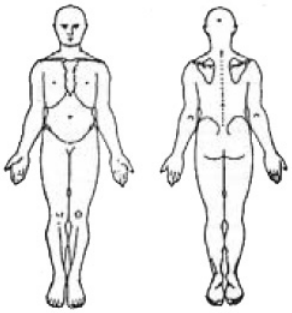
Household Tasks

_____
_____

Outdoor Tasks

_____
_____

INDICATE THE LOCATION OF YOUR PAIN ON THE DIAGRAM:



GENERAL HEALTH

Do you have any of the following?

Diabetes?	Y	N
Heart Trouble?	Y	N
Epilepsy?	Y	N
High Blood pressure	Y	N
Circulation problems?	Y	N
Osteoporosis?	Y	N
Bowel/Bladder Problems?	Y	N
AIDS/HIV positive?	Y	N
Do you smoke?	Y	N
Have you ever had cancer?	Y	N
Have you ever experienced dizziness or blackouts?	Y	N
Sudden weight loss?	Y	N
Breathing problems?	Y	N
Are you pregnant?	Y	N
Recent surgery?	Y	N
Arthritis?	Y	N

Describe any other health problems:

_____
_____

List any allergies

_____
_____

List all medications you are taking

_____
_____

What do you hope to gain from your treatment?

_____

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CONSENT FOR THE COST OF PROFESSIONAL SERVICES

Professional Services at York Rehab Associates are not covered by OHIP. Payment is due when the service is provided. Many Extended Health Plans cover part of all of the fees for our services, but they require that you pay for the service first, then submit your receipt for reimbursement. This is a requirement set out by the Insurance Companies, and we are required by law to comply. In the case of WSIB or Motor Vehicle Accidents claims, we can submit our fees directly to the WSIB or the Insurance Company. However, there is no guarantee of payment without prior approval. Please be aware that you are responsible for any fees incurred on your behalf. Therefore, it is your decision whether to start treatment immediately, or to wait for approval.

I (name) _____ understand that I am responsible for the payment of all fees associated with the service that is provided to me. I am aware that York Rehab Associates HAS/HAS NOT received prior approval from WSIB or my Insurance Company for payment of any fees related to my treatment. I agree to be responsible for any and all costs associated with my treatment at York rehab Associates.
Signature: _____ Date: _____

CONSENT FOR PERSONAL INFORMATION

I understand that York Rehab Associates, acting as *Health Information Custodian*, will collect some personal information about me, in order to provide me with physiotherapy/chiropody services. I have reviewed York Rehab Associates' Privacy Policy about the collection, use and disclosure of personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I may have about the privacy policies at York Rehab Associates and they have been answered to my satisfaction.

I consent to the collection, use and disclosure of personal information about me as set out in York Rehab Associates Privacy Policy.

- ☐ I consent to messages being left at my home phone number, on answering machines or with family members.
- ☐ I consent to messages being left at my work phone number.
- ☐ I consent to my therapist sending information to my family doctor and/or other health care providers involved in my care.

Special Notes or Condition:_____

_____

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

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