
Insurance Name

Policy Number

Claim Number

Adjuster Name

Adjuster Phone Number

HAVE YOU BEEN INVOLVED IN A WSIB INJURY? Yes No

(If yes, please fill in the WSIB information required below)

Date of Injury
Number

Claim Number

WSIB Adjudicator

Adjudicator

The health information requested on the following forms will assist us in treating you safely. If you have any questions about the requested information, please feel free to ask. Your written permission is required to release any information, unless required by law.

PRIMARY REASON FOR YOUR VISIT: _____

DESCRIBE YOUR GENERAL HEALTH: _____

ARE YOU RECEIVING TREATMENT FROM OTHER HEALTH CARE PROFESSIONALS? YES / NO (Please explain below)

Please circle areas of complaint below and on a scale of 1-10 rate your level of pain.
No pain _____ worst possible pain

HAVE YOU EVER EXPERIENCED PAIN OR INJURY TO?

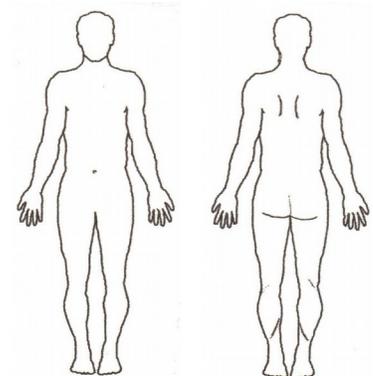
- Shoulders Hips Head Sacroiliac Joints
- Arms Legs Neck Pelvis
- Elbows Knees Mid Back Hands
- Feet Lower back

Briefly provide relevant details:

CIRCLE AND EXPLAIN (DATES, PROCEDURES, ETC) IN THE AREA BELOW:

- YES NO** HAVE YOU EVER BEEN IN A CAR ACCIDENT?
- YES NO** HAVE YOU EVER EXPERIENCED A HARD FALL INTO YOUR BACK OR BUTTOCKS?
- YES NO** HAVE YOU EVER EXPERIENCED A HARD BLOW TO YOUR HEAD OR A CONCUSSION?
- YES NO** HAVE YOU EVER HAD ANY SURGICAL PROCEDURES?
- YES NO** DO YOU HAVE A PIN, PLATE OR SCREW IN YOUR BODY?

Please Explain: _____



DO YOU HAVE ANY CURRENT/PAST MEDICAL CONDITIONS.

**CURRENT MEDICATIONS
MEDICATION**

REASON FOR TAKING

ANY ALLERGIES TO MEDICATIONS? IF SO WHICH ONES

TOBACCO USE: AVERAGE PACKS PER DAY ____ FOR ____ YEARS.

AVERAGE NUMBER OF ALCOHOL- CONTAINING BEVERAGES PER WEEK: ____

DO YOU AT THE PRESENT TIME EXPERIENCE:

YES NO DIZZINESS, WEAKNESS, FAINTING, VERTIGO, DROP ATTACKS OR DISORIENTATION

YES NO DISTURBANCES OF VISION, SPEECH, CO-ORDINATION OR BALANCE, OR DIFFICULTY SWALLOWING

YES NO NUMBNESS OR PINS AND NEEDLES IN ANY PART OF YOUR BODY? (where?)

YES NO DIFFICULTY WITH BOWEL OR BLADDER FUNCTION

YES NO COUGH, SHORTNESS OF BREATH, CHEST PAIN, OR PALPATATIONS

YES NO POOR APPETITE, NAUSEA OR VOMITING

YES NO DIFFCULTY SLEEPING

YES NO A SIGNFICANT WEIGHT CHANGE IN THE PAST YEAR

HAVE YOU EVER CONSULTED A PHYSICIAN FOR ANY OF THE ABOVE: (If yes please explain)

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

DIABETES
BLOOD PRESSURE

HEART DISEASE/ PROBLEMS

CANCER

HIGH OR LOW

TUMOR

STROKE/CVA

ALLERGIES

EPILEPSY (TYPE?)

HEPATITIS

ASTHMA

HIV/AIDS

MIGRAINES

STD'S

HEADACHES (type?)

TUBERCULOSIS

SKIN CONDITIONS

ARTHRITIS

OTHER _____

FAMILY HISTORY: PLEASE IDENTIFY ANY PROBLEMS LISTED ABOVE THAT HAVE OCCURRED IN YOUR IMMEDIATE FAMILY (indicate family members affected)

I understand the above and agree to give consent to the health practitioners for treatment at Alliance Physio. I understand that in order to provide safe treatment, my health practitioner may need to communicate with my physician regarding my condition and treatment. I understand that Alliance Physio practitioners and staff will collect, use and protect my personal information as set out in the clinics privacy policy.

Patient/ Guardian Signature

Date