Alliance Physio

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alliancephysiowellness@gmail.com

_____ _____ _____
SURNAME **FIRST NAME** **DATE**

_____ _____ _____
Parent/Guardian Name (under 18 yrs) **OHIP # (for Dr. Amin)** **Contact Email**

_____ ____ ____ _____ _____
DOB: MONTH **DAY** **YEAR** **Gender** **Emergency Contact: Name/Number**

_____
HOME ADDRESS **CITY** **PROV** **POSTAL CODE**

(___)_____ (___)_____ (___)_____
HOME PHONE **WORK PHONES** **CELL**

Would you like to sign up for our newsletter? (Circle One) YES NO

_____(____)_____
FAMILY PHYSICIAN NAME ADDRESS TELEPHONE

Did your Doctor refer you for treatment for this problem/ injury? Yes / No
If **yes** which one…..

o Physiotherapy o Osteopathy o Chiropractor o Dr. Amin (Sports Specialist)

HOW DID YOU HEAR ABOUT US? Please be specific:
_____

PRIVATE INSURANCE INFORMATION (PRIMARY INSURANCE)

_____ _____ _____ _____
Insurance Company Members Name Plan Number ID Number

PRIVATE INSURANCE INFORMATION (SECONDARY INSURANCE)

_____ _____ _____ _____
Insurance Company Members Name Plan Number ID Number

HAVE YOU BEEN INVOLVED IN A CAR ACCIDENT AND WILL BE CLAIMING UNDER MVA? Yes No

(If yes, please fill in the below car insurance information)

_____ _____ _____
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	Claim Number	WSIB Adjudicator	Adjudicator Number

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)

_____

_____

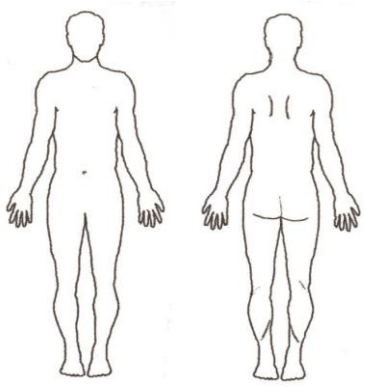
Please circle areas of complaint below and on a scale of 1-10 rate your level of pain.

No pain _____ **worst possible pain**

1 2 3 4 5 6 7 8 9 10

HAVE YOU EVER EXPERIENCED PAIN OR INJURY TO?

o Shoulders	o Hips	o Head	o Sacroiliac Joints
o Arms	o Legs	o Neck	o Pelvis
o Elbows	o Knees	o Mid Back	o Hands
o Feet	o 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	**REASON FOR TAKING MEDICATION**
_____	_____
_____	_____
_____	_____

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 <u>AT THE PRESENT</u> 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	☐ HEART DISEASE/ PROBLEMS	☐ CANCER	☐ HIGH OR LOW BLOOD PRESSURE
☐ 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**