New Patient Information

Personal Information

Last Name	**First Name**	**Middle Initial**
Address: Street		**Unit #**
City	**Province**	**Postal Code**
Date of Birth (Day/Month/Year)		
Home Phone #	**Work Phone #**	**Cell Phone #**
May the clinic leave you messages relating to your visits? □**YES** □ **No**		
Email		
Employer		**Occupation**
Emergency Contact Name and Relationship		**Phone #**

How did you hear about the clinic? _____

Which members of the clinic will you be seeing?

□ **Chiropractor** □ **Physiotherapist** □ **Massage Therapist** □ **Naturopath** □**Personal Trainer**

Family Doctor
Name _____
Phone # _____
Fax # _____

Specialist
Name _____
Phone # _____
Fax # _____

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New Patient Information

Health Information

What are your health concerns and/or reasons for coming to the clinic, in order or importance?

1. _____
2. _____
3. _____

What seems to make the condition better? _____

What seems to make the condition worse? _____

Has the condition; □ Gotten worse □ Gotten Better □ Stayed the same

Does the pain radiate or "shoot" anywhere? _____

Have you had this pain before? If yes, when? _____

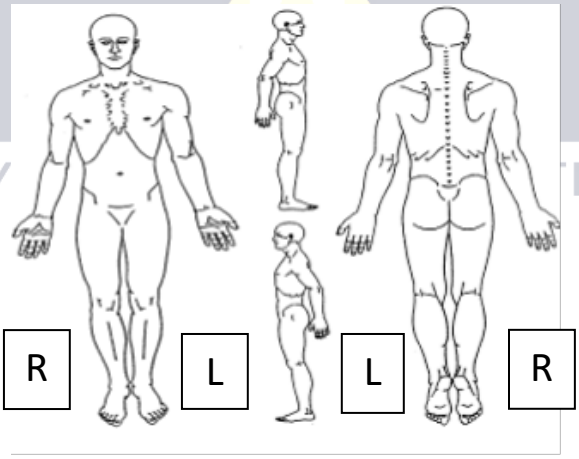
Have you had treatment for this issue in the past? _____

Is this a work related issue or a result of a motor vehicle accident? If yes, please specify.

_____

Instructions: *Mark these drawings according to where you feel your pain, by referring to the key below.*

Sharp /////	Burning XXXXX	Pins & Needles OOOOO	Aching +++++
Stabbing VVVVV	Numbness -----	Dull *****	Other vvvvv



Please circle your current pain level

no pain 0 1 2 3 4 5 6 7 8 9 10 **worst pain imaginable**

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Physical history

Musculoskeletal		Nervous System		Cardio-Vascular-Resp.	
Neck problems		Numbness		Chest pain	
Upper back problems		Loss of feeling		High/Low blood pressure	
Shoulder problems		Headaches		Difficulty breathing	
Low back problems		Dizziness		Persistent Cough	
Elbow problems		Fainting		Coughing phlegm/blood	
Knee problems		Confusion		Lung problems	
Ankle/foot problems		Depression		Diabetes	
Arthritis		Concussion		Asthma	
Other:		Anxiety		Varicose veins	
		Loss of balance		Hypoglycemia	
		Paralysis		Angina	
		Seizures		Murmur/palpitations	
		Forgetfulness		Hemophilia	
Gastrointestinal/Endocrine		**Genito-Urinary System**		**Ears/Nose/Eyes/Throat**	
Poor appetite		Painful urination		Vision problem	
Excessive hunger/thirst		Excessive urine		Ear ringing	
Heat/cold intolerance		Discoloured urine		Ear infections	
Nausea/vomiting		Urgency to urinate		Hearing loss	
Bloody/black stool		Recurring infections		Voice changes	
Weight loss/gain		Kidney stones		Gum/teeth/jaw problem	
Ulcer				Nasal discharge	
Thyroid problems				Nose bleeds	
Liver/Gall bladder problem				Sinus problems	
Female		**Male**		**Skin**	
PMS		Testicular pain		Moles	
Irregular cycle		Itching		Rashes	
Irregular bleeding/discharge		Sores		Acne	
Pregnancy		Irregular discharge/bleeding		Dryness	
Sores		Hernia		Itchiness	
Sexual concerns		Sexual concerns		Psoriasis	
Breast lumps/pain/tenderness/discharge		Chest lumps/pain/tenderness/discharge		Eczema	
Hernia					

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Family history

Illness	Circle		Family member
Alcoholism	Yes	No	
Allergies	Yes	No	
Anemia	Yes	No	
Arthritis	Yes	No	
Asthma	Yes	No	
Cancer	Yes	No	
Depression	Yes	No	
Drug abuse	Yes	No	
Diabetes	Yes	No	
Digestive problems	Yes	No	
Heart disease	Yes	No	
High blood pressure	Yes	No	
Kidney disease	Yes	No	
Mental illness	Yes	No	
Seizure	Yes	No	
Stroke	Yes	No	
Thyroid disorder	Yes	No	
Other	Yes	No	
Family history unknown	Yes	No	

Please indicate any serious conditions, illnesses, injuries and/or hospitalization

_____

_____

Please indicate any medications and/or supplements you are currently taking

_____

Lifestyle

Do you exercise? If yes, how many times per week? _____

Do you smoke? If yes, how many packs per day/week? _____

How would you rate your stress level? □ Mild □ Moderate □ Severe

ACTIVE HEALTH INSTITUTE

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Physiotherapy Consent

Consent for physiotherapy assessment and treatment

I agree to participate in a physiotherapy assessment, performed by a Registered Physiotherapist at The Active Health Institute. I understand that the assessment will include a detailed medical history and physical exam. I understand that the physiotherapist will inform me of my treatment options and that I may consent to further treatment at that time.

Physiotherapy Cost/Session

Initial Assessment (includes treatment)	$130.00
Pelvic Floor Initial Assessment (includes treatment)	$130.00
Subsequent treatment	$85.00
Complex treatment (45min)	$100.00
Complex treatment (60min)	$130.00
No Show (24hr cancellation policy)	$85.00

Cancellation Policy

Your appointment time has been reserved especially for you. If you are unable to keep this reservation, please provide us with at least 24hrs of notice so that another patient can use this time. If you do not provide sufficient notice, you will be charged a "No Show" fee, which is equivalent to the cost of the treatment.

Payment Policy

We require payment at every visit. Accepted forms of payment include; cash, debit, Visa and Mastercard.

Consent for collection of personal information and privacy policy

I understand that in order to provide me with physiotherapy services, Active Health Institute will collect some personal information about me. We are committed to collecting, using and disclosing your personal information responsibly.

Disclosure:

1. The patient's doctor/health practitioner(s)
2. Other health practitioners of the Active Health Institute for the purpose of supporting patient health.

I have reviewed Active Health Institute's Privacy Policy regarding;

- The collection, use and disclosure of my personal information
- The steps taken to protect my information
- My right to review my personal information

I understand how the Privacy Policy applies to me. I have been given a chance to ask questions I have regarding the Privacy Policy and they have been answered to my satisfaction.

Patient Signature: _____ **Date**: _____

Patient Name (Please print): _____ **Witness**: _____