Patient Intake Form

MVA ☐ WSIB ☐ Private ☐ Date: _____

Please print clearly. If you have any questions, please do not hesitate to ask. Thank you.

Client Name:

Address: Email:

City: Province: BC Postal Code:

Phone 1: Phone 2:

Date of Birth: Pronouns: _____

DAY MONTH YEAR

Extended Health Care

Insurance Company: _____ Name on Card: _____

Policy: _____ ID: _____ Birthday of Policy Holder: _____

What brought you to Guelph Rehab Centre? (*Please select one*)

Direct Referral by: (please complete next section)

- ☐ Family Physician
- ☐ Specialist (Please specify: _____)
- ☐ Employer
- ☐ Insurance Company
- ☐ Lawyer
- ☐ Rehab Consultant
- ☐ Health Bound

Self Referral

- ☐ Brochure (source _____)
- ☐ Family / Friend
- ☐ Window Signage
- ☐ Returning Patient
- ☐ Website
- ☐ Bus Advertisement
- ☐ Radio Commercial
- ☐ *Other*: _____

Family Physician or Specialist Information ☐ same as **Referral Source** above

Doctor Name:

City: Province: BC Postal Code:

☐ **Emergency Contact or** ☐ **Guardian (for minor patients)**

Name: Relationship:

Phone:

Payment Responsibility

I understand that I am responsible for all fees incurred at Guelph Rehab Centre; this applies also to Motor Vehicle Accident and WSIB claims. I consent to Guelph Rehab Centre billing all insurance for treatment on my behalf; I agree to pay for any outstanding fees on my account that my insurer may not cover. I am aware of the 35.00 fee for missed or cancelled appointments without 24 hours' notice.

_____ _____

Signature **Date**

Guelph Rehab Centre
INNOVATIVE HEALTHCARE

MEDICAL HISTORY / INITIAL EVALUATION FORM

PATIENT INFORMATION	Date:
Name:	Employer:

REHAB INFORMATION	
Chief Complaint/Ailment/Injury	
Date of Injury	
How were you injured?	

Have you received therapy for this condition?	☐ Yes	☐ No	When?	# of Visits
Has your condition been getting:	☐ Worse	☐ Same	☐ Better	
Are your symptoms:	☐ Constant		☐ Intermittent	

PLEASE MARK ALL THAT APPLY		
	Makes Better	Makes Worse
Bending	☐	☐
Sitting	☐	☐
Rising	☐	☐
Changing Positions	☐	☐
Movement	☐	☐
Standing	☐	☐
Walking	☐	☐
Lying	☐	☐
Rest	☐	☐
Heat or Ice	☐	☐
Medication	☐	☐
Cough or Sneeze	☐	☐

CIRCLE THE NUMBER THAT BEST CORRESPONDS TO YOUR PAIN	
At Best:	At Worst:
◯ 0	◯ 0
◯ 1	◯ 1
◯ 2	◯ 2
◯ 3	◯ 3
◯ 4	◯ 4
◯ 5	◯ 5
◯ 6	◯ 6
◯ 7	◯ 7
◯ 8	◯ 8
◯ 9	◯ 9
◯ 10	◯ 10

PREVIOUS MEDICAL INTERVENTION
☐ X-ray/ MRI
☐ Cat Scan
☐ Injections
Other:

MEDICAL INFORMATION (MARK ALL THAT APPLY)

☐ Pacemaker	☐ Heart Trouble	☐ Medications
☐ Allergies	☐ HIV or Hepatitis	☐ History of Smoking
☐ Stroke	☐ Anemia	☐ Epilepsy/Seizures
☐ High Blood Pressure	☐ Diabetes	☐ Fibromyalgia
☐ Blood Clots	☐ Shortness of Breath	☐ Myofascial Pain
☐ Arthritis	☐ Motion Sickness	☐ Cancer
☐ Difficulty Swallowing		

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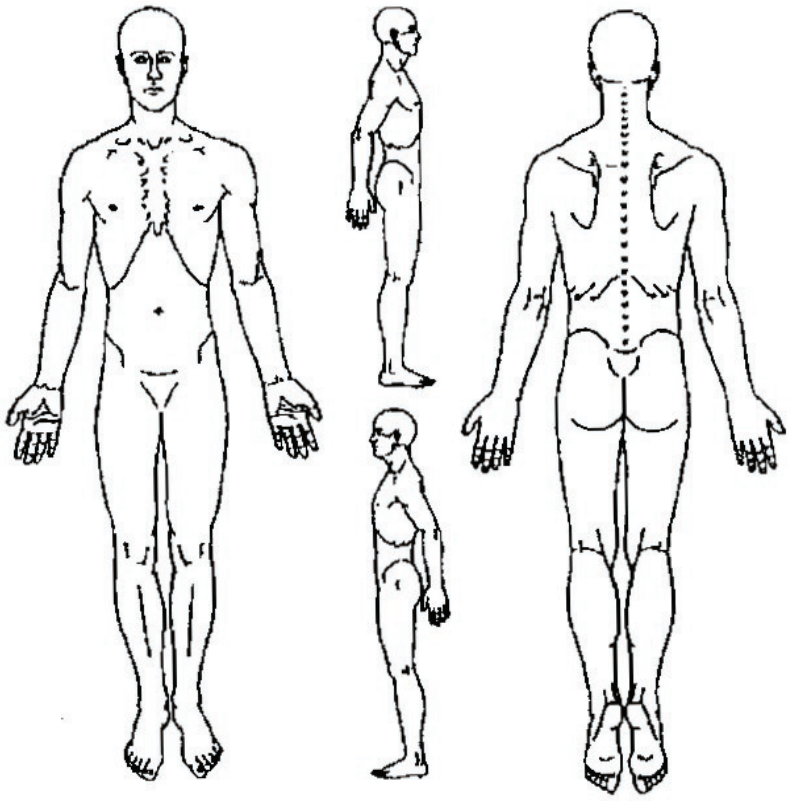
Tel: 519-265-7343 Fax: 519-265-7342

Guelph Rehab Centre
INNOVATIVE HEALTHCARE

MEDICAL HISTORY / INITIAL EVALUATION FORM

DRAW IN AREAS OF PAIN ON BODY DIAGRAMS USING APPROPRIATE SYMBOLS (use highlight tool).



SEVERE PAIN	.....
MODERATE PAIN	00000000
DULL ACHE	∩∩∩∩∩∩
RADIATING PAIN	↑↓↑↓↑↓↑↓
NUMBNESS/TINGLING	XXXXXX

WHAT ARE YOUR GOALS TO BE ACHIEVED BY THE END OF THERAPY?

_____

OTHER INFORMATION:

SIGNATURE: _____

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