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:
FIRST NAME INITIAL LAST NAME

Address: Email:

City: Province: Postal Code:

Primary Phone: Secondary Phone:

Date of Birth:
DAY MONTH YEAR

Pronouns: ____________________

Sex: Female Male

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:
SALUTATION FIRST NAME INITIAL LAST NAME

City: Province: Postal Code:

☐ Emergency Contact or ☐Guardian (for minor patients)

Name:
FIRST NAME LAST NAME RELATIONSHIP

Phone:

Please send me appointment reminders by:

☐ Email ☐ Text Message ☐ Automated Phone Call

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**

CONSENT TO ASSESSMENT & TREATMENT

Name: ____________________ Date: _______________________

I consent to be treated, of my own free will, for the following complaint(s):

____

I acknowledge that my therapist has provided me with such information as it is pertinent to assessment and/or treatment for the above complaint(s). Alternative courses of treatment, where applicable and relevant, have been explained to me as well we the possible risks and side effects of such treatment. I understand fully the consequences of having treatment/refraining from treatment. I appreciate that I may revoke consent (written or verbal) at any time.
In compliance with the "Consent to Treatment Act", I provide my full voluntary informed consent to be treated and/or assessed by:

☐	Kylie Watkins	Chiropractor
☐	Chris Sarro	Physiotherapist
☐	Mike Cazzola	Physiotherapy Resident
☐	Frank DeStefano	Massage Therapist
☐	Dave Ursomarzo	Massage Therapist
☐	Lynn Jeaurond	Occupational Therapist
☐	Jessica Hermack	Chiropodist

CONSENT TO RELEASE INFORMATION

☐ I give **Guelph Rehab Centre** my consent to obtain/release my medical information regarding my treatment to my family physician, referring physician, and other professionals involved in the assessment and/or treatment. I hereby release **Guelph Rehab Centre** and/or its directors, officers, employees, servants, and agents from any and all claims listed above, directly associated with the release of information.

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

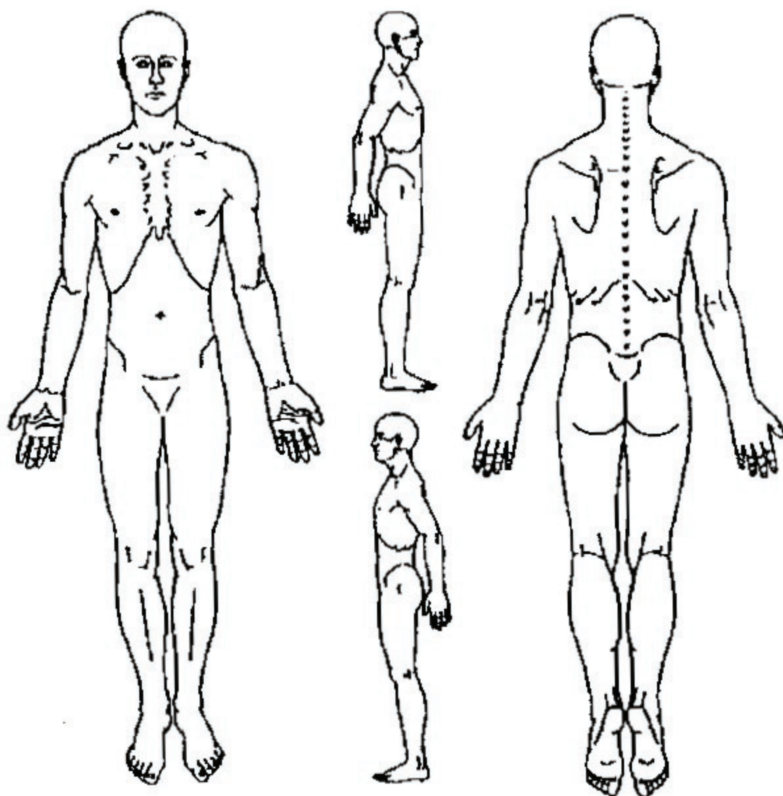
PLEASE MARK ALL THAT APPLY		
	Makes Better	Makes Worse
Bending		
Sitting		
Rising		
Changing Positions		
Movement		
Standing		
Walking		
Lying		
Rest		
Heat or Ice		
Medication		
Cough or Sneeze		

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				

DRAW IN AREAS OF PAIN ON BODY DIAGRAMS USING APPROPRIATE SYMBOLS.



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: ____