Patient Intake Form

Guelph Rehab Centre
INNOVATIVE HEALTHCARE

☐ 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: Ontario Postal Code:

Primary Phone: Secondary Phone:

Date of Birth: Pronouns:
DAY MONTH YEAR

Sex: ☐ Female ☐ Male

Extended Health Care

Insurance Company: _____ Name on Card: _____

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

Were you referred for treatment by any of the following?

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

How did you find the clinic?

☐ Brochure from _____
☐ Family _____
☐ Friend _____
☐ Website/Google
☐ Window Sign
☐ A-frame Sign
☐ Indoor Sign
☐ Other _____

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

Doctor Name:
SALUTATION FIRST NAME INITIAL LAST NAME

City: Province: Ontario 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**

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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	Physiotherapist
☐ Frank DeStefano	Massage Therapist
☐ Dave Ursomarzo	Massage Therapist
☐ Lynn Jeaurond	Occupational Therapist

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

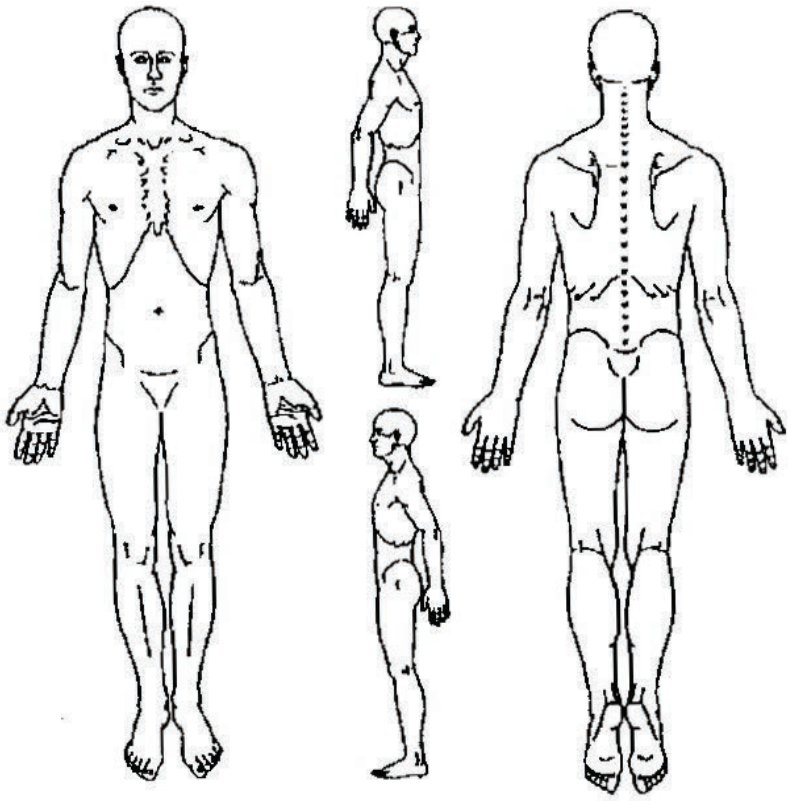
☐	X-ray/ MRI
☐	Cat Scan
☐	Injections

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: _____