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: Postal Code:

Cell Phone: Home Phone:

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:
SALUTATION FIRST NAME INITIAL LAST NAME

City: Province: Postal Code:

☐ Emergency Contact or ☐ Guardian (for minor patients)

Name:
FIRST NAME INITIAL 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. I consent to Guelph Rehab Centre billing my insurance for treatment on my behalf; I agree to pay for any outstanding fees on my account that my insurer does not cover or does not pay the clinic directly.

I am aware of the $50.00 fee for missed or cancelled appointments without 24 hours notice.

_____ _____
Signature **Date**

Consent to Assessment and Treatment

85 Norfolk St. Suite #105, Guelph, ON N1H 4J4
Tel: 519-265-7343 Fax: 519-265-7342

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INNOVATIVE HEALTHCARE

Consent to Assessment and Treatment

Name: _____ Date: _____

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

_____

I acknowledge that my therapist has provided me with information as it pertains 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 as the possible risks and side effects of such treatment. I fully understand 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
	Emily Laudi	Chiropractor
	Dave Ursomarzo	Massage Therapist
	Frank DeStefano	Massage Therapist
	Sangeeta Bera	Physiotherapist
	Krushangi Prajapati	Physiotherapist
	Jay Raval	Physiotherapist

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 released information.

Signature: _____ Date: _____

Guelph Rehab Centre
INNOVATIVE HEALTHCARE

MEDICAL HISTORY / INITIAL EVALUATION FORM

PATIENT INFORMATION	Date:
First Name (print):	**Last** Name (print):

REHAB INFORMATION	
Chief Complaint(s)/ Injury	
Date of Injury	

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 / Ultrasound
	MRI / CT Scan
	Injections

MEDICAL HISTORY (ONLY WHAT IS PERTINENT FOR YOUR CHIEF COMPLAINT)

Medications (only for your complaint)	
Allergies (topical, scents)	
Other: *Anything else you would like your therapist to know that pertains to your current complaint(s)/Injury*	

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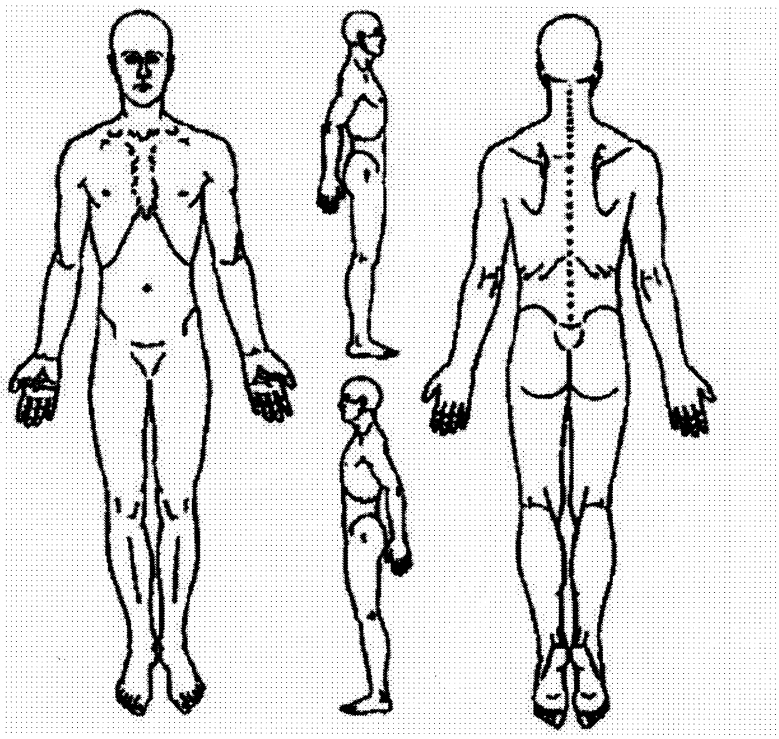
MEDICAL HISTORY / INITIAL EVALUATION FORM

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



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

PATIENT SIGNATURE: _____

THERAPIST NOTES: