Body Align
PHYSIO & REHAB

Unit 4 955 Westney Rd
South Ajax, On L1S 3K7

INTAKE FORM

Patient Information		
Date:		
First Name:	**Last Name**:	**Middle Initial:**
☐ Male ☐ Female ☐ Prefer not to answer		
Email Address:		
Address:		
City:		
Province:		
Postal Code:		
Date of Birth:		
Cell Phone:		
Home Phone:		
Referred to Clinic By:		

Insurance Plan	☐	Family	☐	Friend	☐
Doctor	☐	Close to Work/Home	☐	Website	☐
Yellow Pages	☐	Street Sign	☐	Other	☐

CARE PROVIDER INFORMATION	
Referring Dr:	Phone:
Family Physician**:**	

INSURANCE INFORMATION		
Primary Insurance Name:		
Name of policy holder:		**DOB:**
Plan#:	**ID#:**	
Patient's Relationship to Policy Holder:	Self ☐ Spouse ☐ Child ☐ Other ☐	
Name of Secondary Insurance:		
Name of policy holder:		
Plan#:	**ID#:**	
Patient's Relationship to Policy Holder:	Self ☐ Spouse ☐ Child ☐ Other ☐	

IN CASE OF EMERGENCY
Name of Local the Person:
Relationship to Patient:
Phone#:

PAST MEDICAL HISTORY FORM

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic	☐	☐
Myocardial Infarction	☐	☐
Murmur	☐	☐
Do you have a pacemaker?	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

OTHER CONDITIONS	YES	NO
High Blood Pressure	☐	☐
Rheumatoid Arthritis	☐	☐
High Cholesterol	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐

List all medications you are currently taking:

List all surgeries in the past two years (Including dates):

Are you Pregnant? ☐ Yes ☐ No If so, what week are you in? _____

Painful Body Areas: _____

Have you had any injuries related to work? ☐ Yes ☐ No

If yes, list body part: _____ Date of Injury: _____

Have you had any Auto Accidents? ☐ Yes ☐ No

If yes, list body part: _____ Date of Injury: _____

Have you had Physical Therapy or Massage Therapy before? ☐ Yes ☐ No

CLIENT WAIVER AND RELEASE

By signing below, you the Patient, are aware that there are risks and regulations associated with participating in a Physiotherapy and/or Chiropractic program.

You freely accept and fully assume all responsibility for your risks and all possibilities of personal injury, death, property damage or loss to yourself or and other person as a result of your participation in rehab exercise and all other activities in our clinic. You and your heirs, next of kin, executors, administrators and assigns agree: to waiver all claims, known or unknown, that you have or may have in the future against the clinic including its owners, officers, directors, agents, employees, volunteers, business operators, independent contractors; that the clinic is not liable or responsible for any damage to, loss or theft of your property; to release and forever discharge the clinic from all liability for any personal injury, health, property damage or loss resulting from your participation in rehab exercise or other activities due to any cause, including but not limited to negligence (failure to use such care as a reasonably prudent and careful person would use under similar circumstances), breach of any duty imposed by law, breach of contract, mistake in error or judgement by the clinic; and to be liable for and to hold harmless and indemnify the clinic from all actions, proceedings, claims, damages, costs, demands, including court costs on a solicitor and own client basis, and liabilities of whatsoever nature or kind arising out of or in any way connected with your participation in rehab exercise and other activities.

I understand that the clinic bills according to their Fee Schedule, of which copies can be obtained in the clinic, regardless of co-pay or insurance coverage. I fully understand that the clinic is not responsible for any deductible or co-pay that may be enforced on your plan.

I understand that at the clinic, I may be working with different therapists, men and women, and that I may not see the same therapist each visit.

You may discontinue your physiotherapy or chiropractic treatment at any time with no cancellation fee and will be responsible for only monies owed for visits completed.

I acknowledge that by typing my full legal name below, this constitutes my digital signature.

☐ I acknowledge my digital signature below.

X _____

PATIENT AUTHORIZATION AND INFORMED CONSENT FOR

ASSESSMENT AND TREATMENT

Last Name: First Name: Date of Birth:

I hereby authorize and agree to participate in the initial assessment(s) and the subsequent treatment programs for my present condition(s). I understand that my treatment program may consist of physical and fitness assessment, re-assessment, education, therapeutic modalities (i.e., ultrasound, laser, electrotherapy, heat / cold therapy etc.), manual therapy, acupuncture, postural correction and energy conservation education, therapeutic exercises, conditioning exercise program, functional training etc. I understand and agree that such mentioned services above may be administered by the registered physiotherapist, chiropractor or the support staff (i.e., the Kinesiologist or PTA) under the supervision/prescription of the physiotherapist and/or chiropractor.

I understand that the assessment and the treatment program will be provided as they are deemed necessary by the appropriate health practitioner. I understand that results are not guaranteed. I understand that there are some risks (i.e., cardiovascular and musculoskeletal) associated with the treatment program, although rare, and are not limited to sprains / strains, fractures and burns from modalities. I understand that in the practice of acupuncture, there are some risks to treatment, including but not limited to, minor bleeding, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles. These acupuncture treatments are not necessarily part of every patient's course of therapy, and they would only be performed after consultation with you.

I do not expect the health practitioner to be able to anticipate and explain all risks and complications and I wish to rely on the physiotherapist, chiropractor and/or the kinesiologist to exercise judgement during the course of the treatment program which he/she feels at the time, based upon the facts then known, is in my best interest.

I understand it is my responsibility to fully disclose any of my known medical conditions and all relevant information regarding my condition(s), as well as medications recently taken at the assessment and throughout the course of the treatment program in order to minimize risk. I understand that it is also my responsibility to inform my treating health practitioner or the support staff, at any time, if I feel that any activity during the course of the treatment program may put me at risk for injury.

I have had an opportunity to discuss with the treating physiotherapist, chiropractor, the support staff, the clinic manager and the other staff at regarding the above-mentioned assessments and treatment program. I understand that I am free to stop the assessment and

the treatment program at any time if I so choose. My permission to perform such assessments and treatment program is given willingly.

I have read this consent form and I understand it, and any questions which may have occurred to me have been answered to my satisfaction. By signing below, I consent to participate the above-mentioned assessments and treatment program. I understand that my consent can be withdrawn at any time, but I intend for this consent form to cover the entire course of the assessments and the treatment programs.

I acknowledge that by typing my full legal name below, this constitutes my digital signature.

☐ I acknowledge my digital signature below.

X _____

PAR-Q AND YOU

Last Name: First Name: Date of Birth:

If you are planning to become more physically active than you are now, start by answering the seven questions below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Has your doctor ever said that you have a heart condition AND that you should only do physical activity recommended by a doctor?

☐ Yes ☐ No

Do you feel pain in the chest when you do physical activity?

☐ Yes ☐ No

In the past month, have you had chest pain when you were not doing physical activity?

☐ Yes ☐ No

Do you lose your balance because of dizziness, or do you ever lose consciousness?

☐ Yes ☐ No

Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?

☐ Yes ☐ No

Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?

☐ Yes ☐ No

Do you know of any other reason why you should not do physical activity?

☐ Yes ☐ No

YES to one or more questions....

Talk with your doctor by phone or in person BEFORE you stat becoming more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

I acknowledge that by typing my full legal name below, this constitutes my digital signature.

☐ I acknowledge my digital signature below.

X _____

CANCELLATION POLICY

We Require **a minimum or 24 hours notice for cancellation, or change, or an appointment.** This will enable us to fill the time slot you have vacated with another patient in need of our care.

The cancellation fee for late notice is $50. However, if the appointment is missed **without providing us any notice at all, the cancellation fee is equal to the full fee of the appointment time(s) you have missed.**

Should you arrive late for your appointment, or request to leave early, the full fee for the appointment time(s) you have booked will also be charged.

We will attempt to remind you of your appointments at lease two days in advance. However, please note that we provide this service as a courtesy. Please do not rely on these emails or calls to keep track of your appointments.

Please note: We understand that your time is valuable and therefore we make every effort to keep our schedule running on time. Due to the nature of our work, unexpected delays sometimes occur. Please be assured that under these circumstances you still receive your treatment time.

Thank you for helping us maintain a high level of service for all our clients.

I prefer to receive my appointment reminders by (choose all that apply):

☐ Email ☐ Phone ☐ Text