SUNRISE PHYSICAL THERAPY

#112, 187 Hwy 16A, SPRUCE GROVE, AB. Phone: 780 9608711

Confidential Patient Intake form

First Name:	Middle Name:	Last Name:		
Date of birth (dd/mm/yyyy):	Age:	Gender:	☐ Male	☐ Female
Home Phone:	Alberta health Care No:	Email Id: Can we send you appointment reminders & receipts via email?)☐**Yes** ☐ **No**		
Cell Phone:				

Address:					
Occupation:					
☐ Full time	☐ Part time	☐ Student	☐ Retired	☐ Unemployed	☐ Home maker

Parent/Guardian Name: (If under 18 years of age)	**Parent/Guardian Phone:**
Emergency Contact Name, Phone number: **Relationship:**	
Do you have any Extended Health Benefits? ☐ **YES** ☐ **NO**	If yes, please indicate your extended benefits carrier:
ID Number:	**Policy/Group #**
Policy Holder Name:	**Policy holder date of birth:**
Veterans Affairs Clients: (Card Number)	

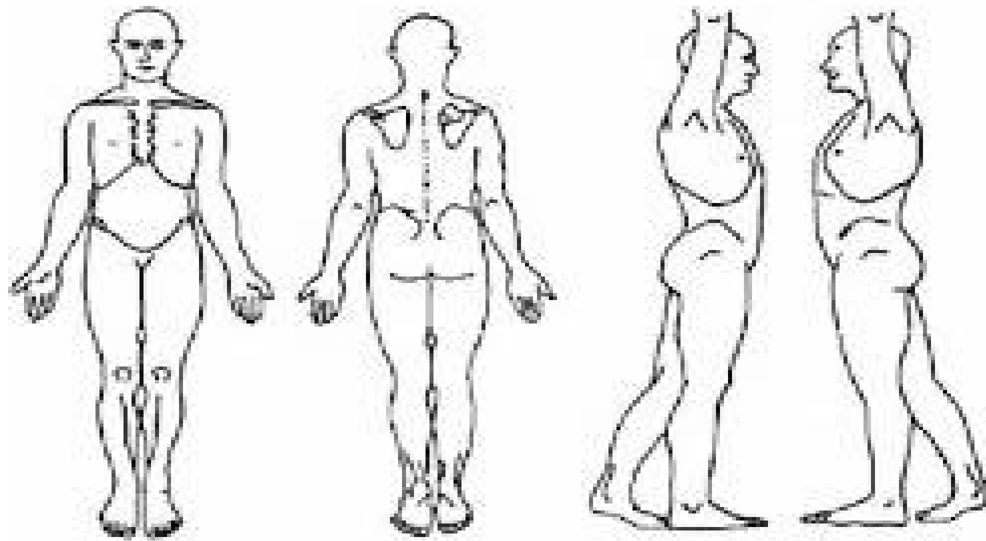
Family Doctor Name:	Referring Physician Name:	Did you get any imaging done (x-rays, Ultra sound, MRI): ☐ YES ☐ NO
Diagnostic Imaging name & address:		
Do you have any medical conditions?	1. 2. 3. 4. 5.	
List any previous surgical procedures and any details/hardware (prosthesis, wires, internal pins/fixators)		
Do you take any prescribed medication? (Please list all medications, supplements etc)	1. 2. 3. 4. 5.	

☐ Motor Vehicle Accident (Please complete if applicable)	
Date of Accident:	Insurance company Name:
Claim #:	Adjuster Name:
Adjuster Phone:	Fax #:

☐ WCB (Please complete if applicable)	
Worker job title:	WCB Claim #:
Employer Business Name:	Contact person for injury:
Employer address:	Employer Phone #:
Body sites involved:	Date of Injury:

How did you hear about our office?		
☐ Family Physician	☐ Family/Friend referral	☐ Google
☐ Website	☐ Street signage	☐ Other

Please indicate on the following diagram, your significant areas of pain/discomfort:



Please describe the nature of your pain:

☐ Sharp pain ☐ Dull (Ache) pain ☐ Throbbing ☐ Burning ☐ Numbness ☐ Shooting

☐ Constant ☐ Frequent ☐ Occasional ☐ Intermittent

Intensity of pain at worst:

1 2 3 4 5 6 7 8 9 10

Have you had physical therapy treatment, for this condition, in the past?

☐ Yes ☐ No if yes, was the treatment effective: ☐ Yes ☐ No

Have you received any treatments from other health professionals for your current or related problems?____

INFORMED CONSENT TO PHYSIOTHERAPY TREATMENT & RELEASE OF INFORMATION

I, the undersigned, voluntarily consent to the physiotherapist & Sunrise Physical Therapy Clinic providing physiotherapy services to me, now and on an ongoing basis, with such treatment to be within the scope of the physiotherapy practice as defined by Physiotherapy Association & College Alberta, including without limitation, such assessments, examinations and techniques, as recommended by the physiotherapist. I consent to the physiotherapist undraping areas of my body to the extent needed to provide treatment while considering my comfort, security and privacy as requested by me. I understand that at any time I may withdraw my consent to treatment by informing the physiotherapist with words to that effect, and then treatment will be stopped. I agree that no assurance or guarantee has been provided to me by the physiotherapist or the clinic as to any of treatment. ________ 🡐 (Initial)

POSSIBLE RISKS ASSOCIATED WITH TREATMENT

I agree that my consent is given while informed of the fact that possible and likely risks to me exist during the course of the treatment, including but not limited to, muscle strains and sprains, bruising, light headaches, dizziness and tenderness. I agree that the physiotherapist is not able to explain unanticipated risks and complications and as such there may be other risks associated with treatment in addition to those identified above. _______🡐 (Initial)

DUTY TO DISCLOSE MEDICAL HISTORY

I agree that I have a duty to fully disclose to the physiotherapist and clinic all medical conditions affecting me, whether or not I believe any medical condition is applicable or relevant to my treatment. I further agree that it is my responsibility to keep the physiotherapist updated and informed of my medical condition. I declare that the information I have provided in the above Medical history form is true, accurate and complete.________ 🡐 (Initial)

DISCLOSURE OF PERSONAL INFORMATION

I understand that it may be desirable from time to time for the physiotherapist and clinic to coordinate my health care with others, including but not limited to other clinic staff, physician, other health care providers, case managers, and insurance claim adjusters, which result in disclosing my personal information (as defined in the Personal Information

Protection Act). I consent to the physiotherapist and clinic disclosing my personal information to other providers, when done in accordance with the Act. I consent to share access between the physiotherapist and the clinic staff to my personal information. I agree that I must expressly withdraw consent of the disclosure of my personal information by providing 2-business day of notice of such withdrawal of consent in writing to the physiotherapist and clinic.______ ← (Initial)

AGREEMENT TO FEES

I understand that I am solely responsible for paying the fees associated with each treatment with each treatment session. I agree to pay this fee that is accordance with the most current fee schedule at the time of each visit.

I understand that if my claim is to be submitted directly to an outside agency for payment and for any reason the third party payer denies the claim and/or refuses to pay all or any of the full amount billed, I am fully and solely responsible for paying the outstanding amount. .______ ← (Initial)

CANCELLATION & NO SHOW POLICY

I understand that I should give 24 hours' notice for cancellation if I am not able to show up for my appointment.

I understand and agree with the criteria listed under Sunrise Physical Therapy clinic policies.

______________________________ ______________________

Patient Name (please print) Date

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Patient Signature (or Legal Guardian)