





**HAVE YOU EVER EXPERIENCED PAIN OR INJURY TO?**

- Shoulders     Hips             Head             Sacroiliac Joints
- Arms             Legs             Neck             Pelvis
- Elbows         Knees         mid Back
- Hands         Feet             Lower Back

**Briefly provide relevant details:**

**CIRCLE AND EXPLAIN (DATES, PROCEDURES, ETC) IN AREA BELOW:**

- YES NO**    HAVE YOU EVER BEEN IN A CAR ACCIDENT?
- YES NO**    HAVE YOU EVER EXPERIENCED A HARD FALL ONTO YOUR BACK OR BUTTOCKS?
- YES NO**    HAVE YOU EVER EXPERIENCED A HARD BLOW TO YOUR HEAD OR A CONCUSSION?
- YES NO**    HAVE YOU EVER HAD ANY SURGICAL PROCEDURE?
- YES NO**    DO YOU HAVE A PIN, PLATE OR SCREW IN YOUR BODY?
- YES NO**    DO YOU HAVE ANY CHILDREN?  
                   No. of Children \_\_\_\_\_ Number of C-Sections \_\_\_\_\_ Are you pregnant now? \_\_\_\_\_

**Please Explain:**

---



---



---

**CURRENT MEDICATIONS**

**REASON FOR TAKING MEDICATION**

---



---



---



---



---



---



---



---



---



---

**DO YOU AT THE PRESENT TIME EXPERIENCE:**

- YES NO**    DIZZINESS, WEAKNESS, FAINTING, VERTIGO, DROP ATTACKS OR DISORIENTATION
- YES NO**    DISTURBANCES OF VISION, SPEECH, CO-ORDINATION OR BALANCE, OR DIFFICULTY SWALLOW
- YES NO**    NUMBNESS OR PINS AND NEEDLES IN ANY PART OF YOUR BODY (where?)

---

- YES NO**    DIFFICULTY WITH BOWEL OR BLADDER FUNCTION
- YES NO**    COUGH, SHORTNESS OF BREATH, CHEST PAIN, OR PALPITATIONS
- YES NO**    POOR APPETITE, NAUSEA OR VOMITING
- YES NO**    DIFFICULTY SLEEPING
- YES NO**    A SIGNIFICANT WEIGHT CHANGE IN THE PAST YEAR



**HAVE YOU EVER EXPERIENCED?**

- YES NO** RECURRENT EAR, THROAT OR SINUS INFECTIONS
- YES NO** RESPIRATORY DISEASE OR DISORDERS (asthma, pneumonia, bronchitis, etc.)
- YES NO** STOMACH, INTESTINAL OR ANY DIGESTIVE PROBLEMS
- YES NO** BLADDER OR KIDNEY PROBLEMS (infection, disease)
- YES NO** GYNECOLOGICAL CONDITIONS (endometriosis, cysts, fibroids, etc)

**HAVE YOU EVER CONSULTED A PHYSICIAN FOR ANY OF THE ABOVE: (If yes please explain)**

---



---



---

**DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS? (Please circle/check)**

- |   |   |
|---|---|
| <input type="checkbox"/> DIABETES               | <input type="checkbox"/> HEART DISEASE / PROBLEMS   |
| <input type="checkbox"/> CANCER                 | <input type="checkbox"/> HIGH OR LOW BLOOD PRESSURE |
| <input type="checkbox"/> TUMOR                  | <input type="checkbox"/> STROKE / CVA               |
| <input type="checkbox"/> ALLERGIES              | <input type="checkbox"/> EPILEPSY (type) _____      |
| <input type="checkbox"/> HEPATITIS              | <input type="checkbox"/> ASTHMA                     |
| <input type="checkbox"/> HIV / AIDS             | <input type="checkbox"/> MIGRAINES                  |
| <input type="checkbox"/> STD'S                  | <input type="checkbox"/> HEADACHES (type) _____     |
| <input type="checkbox"/> TUBERCULOSIS           | <input type="checkbox"/> SKIN CONDITIONS            |
| <input type="checkbox"/> ARTHRITIS (type) _____ | <input type="checkbox"/> OTHER _____                |

**FAMILY HISTORY: PLEASE IDENTIFY ANY PROBLEMS LISTED ABOVE THAT HAVE OCCURRED IN YOUR IMMEDIATE FAMILY (indicate family members affected)**

---



---



---



---

The health practitioners at PhysioPlus Health Group may use manual therapies where the health practitioner places his/her hands on your body. Many techniques will involve contact between your body and the practitioner's body. Body and hand contact may include areas of your chest wall, pelvic floor & pubic bones. If intra-oral work is required, disposable latex or vinyl gloves will be worn. At times, the practitioners may ask you to remove some items of clothing in order to facilitate treatment. If you do not feel comfortable with any part of the treatment, please tell us immediately. The techniques can be discontinued or modified to be comfortable for you.

I understand the above and agree to give my consent to the health practitioner for treatment at PhysioPlus Health Group. I understand that in order to provide safe treatment my health practitioner may need to communicate with my physician regarding my condition and treatment.

I understand that PhysioPlus Health Group practitioners and staff will collect, use and protect my personal information as set out in the clinic's privacy policy, which is available at the front desk.

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

## CANCELLATION POLICY

We require a **minimum of 2 business days** notice for cancellation of 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 is equal to the full fee for the appointment time you have booked.**

We understand that last minute changes in your schedule are sometimes impossible for you to avoid. However, we must charge a cancellation fee equal to **the full fee for the appointment time reserved for you.**

Should you arrive late for your appointment or request to leave early, the full fee for the appointment time you have booked will also apply.

We will attempt to remind you of your appointment a day or two in advance, however please note that we provide this service as a **courtesy**. Please **do not** rely on these calls to keep track of your appointments. A cancellation fee equal to the full fee for the appointment time reserved for you will also apply for missed appointments.

**Please Note:** We understand that your time is valuable and therefore 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 will still receive your full treatment time. Thank you for helping us to maintain a high level of service for all our clients.

**I understand the above and agree to abide by this policy:**

\_\_\_\_\_  
Patient/Guardian or Parent Signature

\_\_\_\_\_  
Date

## PAYMENT POLICY & INSURANCE COVERAGE

Fees for Osteopathic treatment, Physiotherapy and Massage Therapy treatments, and orthotics are covered by most extended health care plans. Each plan can vary greatly as to the amount covered **per treatment** and the **yearly maximums** covered. As the policy holder, **it is your responsibility** to contact your insurance company and confirm the **exact** details of your coverage. Our front desk staff would be happy to assist you with any questions regarding your insurance coverage for our services.

Payment is due in full by **cash, debit, Visa, MasterCard, or cheque** at the end of each treatment session.

A receipt with all the required information will be provided to you, which you can then submit to your insurance company for re-imburement.

**I understand the above and agree to abide by this policy:**

\_\_\_\_\_  
Patient or Guardian/Parent Signature

\_\_\_\_\_  
Date