FULL SPECTRUM CHIROPRACTIC

PHYSIOTHERAPY PATIENT INFORMATION SHEET

#110, 849 Premier Way • Sherwood Park, AB T8H 0V2 • Phone: 780 464 1029 • Fax: 780 464 3120

PLEASE COMPLETE FULLY AND ACCURATELY

Name: _____ Date of birth: _____ Age: _____ Gender:_____

Address: _____ City:_____ Postal code: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Alberta Health Care Number: _____

Emergency contact (**Name, Tel. # & Relationship**): _____

E-Mail Address (for appointment reminders): _____

How were you referred to this clinic? Please specify who/where: _____

Are your injuries related to your **Workplace (WCB claim)**? ☐ N ☐ Y If yes, date of incident: _____

Please note that Megan Ewanowich does not accept WCB (Worker's Compensation Board) Cases

Are your injuries related to a **Motor Vehicle Accident**? ☐ N ☐ Y If yes, date of accident: _____

FEMALES: Are you pregnant? ☐ N ☐ Y If yes, how many weeks? _____

CURRENT HEALTH HISTORY

CURRENT COMPLAINT(s), with detail – *in order of importance to you*

1) _____

2) _____

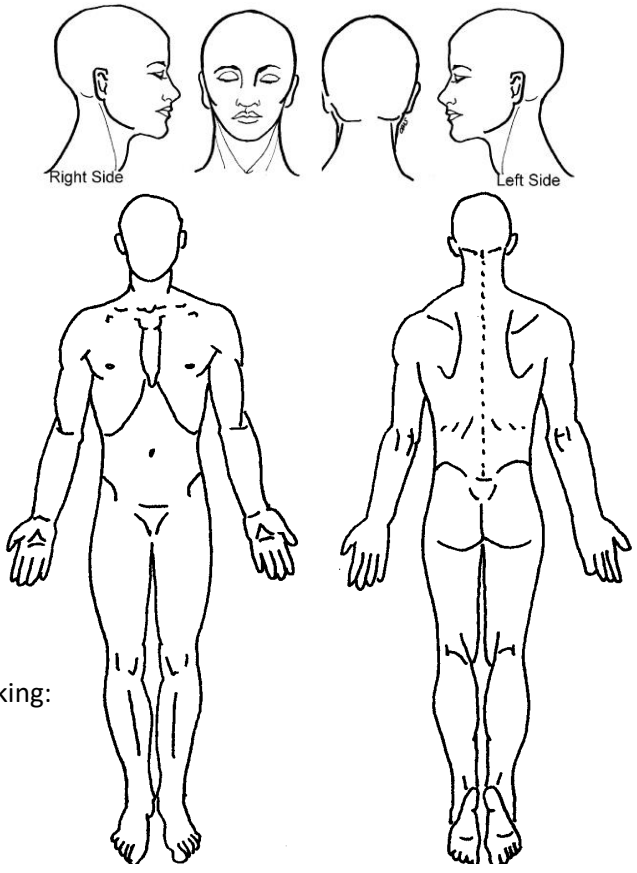
3) _____

When did this pain start? _____

_____

_____

ON THE DIAGRAMS BELOW CIRCLE ALL PAINFUL AREAS

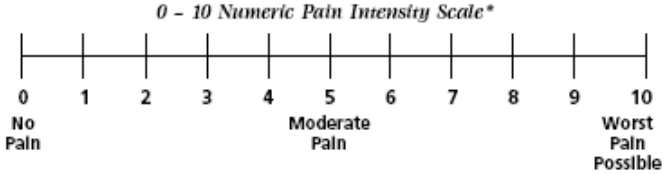


DESCRIBE YOUR PAIN (check):

☐ sharp & stabbing ☐ tingling (pins & needles) ☐ numb

☐ burning ☐ dull ache ☐ stiff & tight

Circle your current level of pain/discomfort



List any **medications, supplements** (vitamins, etc.) that you are currently taking:

_____ _____

_____ _____

_____ _____

_____ _____

Signature: _____ **Date**: _____

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FAMILY HEALTH HISTORY

Have you or anyone in your family had the following (**please specify whom**):

☐ Heart disease _____ ☐ High blood pressure _____
☐ Cancer _____ ☐ Diabetes _____
☐ Stroke _____ ☐ Genetic Conditions: _____
☐ Other _____

PAST HEALTH HISTORY

List any previous **Surgeries** and the year(s) they occurred:

_____

_____

List any previous **Fractures/Injuries** and the year(s) they occurred:

_____

_____

GENERAL HEALTH INFORMATION

Please check symptoms you have experienced in the past or currently:

☐ Seizures/Stroke	☐ Bleeding Problems	☐ Chest Pain/Angina	☐ Difficulty Speaking/Swallowing
☐ Osteoporosis	☐ Anemia	☐ High Blood Pressure	☐ Recent Fall (last 6 months)
☐ Osteoarthritis	☐ HIV/AIDS/Hepatitis	☐ Dizziness/Fainting Spells	☐ Pacemaker/ICD
☐ Rheumatoid Arthritis	☐ Respiratory Condition	☐ Hearing Loss/Change	☐ Nausea/Vomiting
☐ Headaches	☐ Chronic Pain	☐ Memory Loss/Change	☐ Changes in Bladder Function
☐ Tobacco/Cannabis use	☐ Depression	☐ Vision Loss/Change	☐ Changes in Bowel Function
☐ Poor Balance	☐ Numb/Tingling	☐ Fever/Chills/Sweats	☐ Unexplained Weight Loss
☐ Increased Pain at night	☐ Recent Hospitalization	☐ Skin Condition/Open Wounds	☐ Metal Implants/IUD

FEES

Type of appointment	Fee
Initial visit	$120.00
Adult Subsequent Visit (Ages 18+)	$95.00
Youth Subsequent Visit (Under 18)	$85.00

Do you have extended health benefits? ☐ YES ☐ NO Benefits Provider: _____

- *Please check at the front desk if your Insurance Provider is eligible for direct billing.* For direct billing, **claims are submitted under PHYSIOTHERAPY**. We are submitting the claim on your behalf and your Insurance Provider predetermines approval. If your claim is rejected, not covered or processed as pending, **you are responsible for payment on your service at the time it is rendered.**
- If you cannot attend an appointment, or no longer need it, please give **2 HOURS NOTICE** so that another patient may receive care during that time. Please be courteous to other patients who are in need of an appointment. Failure to do so will result in a $40.00 fee. When you book an appointment, that time is set aside specifically for you and reserved. We are often booked back to back so arriving late (**10-15 minute maximum**), will be cut into your appointment time, and we will only be able to give you the remaining time in your session. In these cases, the full session fee will apply. (More than 15 minutes will be considered a missed appointment and will have to be rescheduled and will result in the full fee of the appointment.)

I have read the above and understand the expectations of the cancellation policy, that I am responsible for all charges relating to my visit and that the visit will be bill to my extended health benefits under physiotherapy (if applicable). The statements made on this form are accurate, to the best of my recollection, and I agree to allow this office to examine me for further evaluation.

Signature: _____ Date: _____ Staff Initials: _____

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CONSENT FOR TREATMENT

- I understand that the health information collected is confidential in nature and will not be released without my prior written consent.
- I hereby consent to and authorize Megan Ewanowich, Licensed Physical Therapist, to perform therapeutic assessment and treatment.
- I understand that I can ask questions at any time, to clarify information and instructions provided by the therapist.
- I understand that I can withdraw my consent for participation at any time.
- I understand that the nature, purpose, and probable risks & benefits of all proposed treatments will be reviewed with me, including:

Acupuncture Therapy	Exercise Therapy
Minor Bleeding/Bruising	Muscle/Joint Soreness
Infection	Dizziness
Fainting	Risk of Falls
Nerve/Tissue Injury	Aggravation of Symptoms

- I confirm that I have informed the therapist of all pre-existing medical conditions that may impact my treatment, including: pregnancy, presence of a pacemaker or metal implants, history of seizures, & the use of blood thinners.

Acknowledgement:

I acknowledge that I have read and understood this Agreement, that I appreciate and accept the risks associated with treatment and that I have executed this Agreement voluntarily.

Client's name: (*Please Print*) _____

Signature: _____ Date: _____

Practitioner: _____ Date: _____

FOR PRACTITIONER USE		
Problems/Concerns/Physical Diagnosis:	**Treatment Goals:**	**Treatment Plan:**