**REACTIVATE PHYSIOTHERAPY AND MASSAGE**

**Patient Intake Form**

All information is retained as part of your confidential patient record.

FIRST NAME:       LAST NAME:

STREET ADDRESS:       CITY:

PROVINCE:       POSTAL CODE:

CELL #       WORK #      HOME #

DATE OF BIRTH: Click here to enter a date. EMAIL ADDRESS:

OCCUPATION:      EMPLOYER:

EMERGENCY CONTACT:       PHONE #

FAMILY DR:      PHONE #

REFERRING DR:      PHONE #

***ARE YOU HERE AS A RESULT OF A MOTOR VEHICLE ACCIDENT* (MVA)? YES  NO**

**(IF YES)** NAME OF YOUR AUTO INSURANCE COMPANY:

INSURANCE ADJUSTER:       PHONE #

CLAIM #       POLICY #       FAX #

DATE OF ACCIDENT Click here to enter a date.

**(MVA ONLY)** ***DO YOU HAVE PRIVATE MEDICAL COVERAGE***? **YES  NO**

NAME OF MEDICAL INSURANCE COMPANY:

POLICY/PLAN NUMBER :       ID NUMBER :

PLAN DETAILS: PERCENTAGE COVERED:      % TO MAXIMUM OF: $

***IS YOUR INJURY COVERED BY WSIB (WORKERS COMPENSATION BOARD*)? YES  NO**

(IF YES) WSIB CONTACT NAME AND PHONE NUMBER

CLAIM#      DATE OF ACCIDENT Click here to enter a date.

**WORKER’S COMPENSATION CLIENTS:** If, for any reason, WSIB declines to cover your Physiotherapy Claim, ***YOU YOURSELF WILL BE RESPONSIBLE*** to pay the outstanding balance on your account

**PLEASE NOTE** that **OHIP does not cover Private Physiotherapy or Massage Therapy in Ontario.**

Therefore, YOU or your medical insurance company are directly responsible for payment of any services provided to you by Reactivate Physiotherapy and Massage. Payment must be made after each session or at the end of each week. ***Initial assessments must be paid for at the time of your first visit.***

Are you presently receiving or have you ever received any of the following treatment for your

**current** problem?

Chiropractic  Massage Occupational Therapy Naturopathic

Reflexology  Acupuncture  Physiotherapy Podiatry/Chiropody

Please **check**  any of the following conditions that **you** have:

Arthritis  Hernia

Diabetes  Depression

Thyroid Condition  Osteoporosis

Dizziness/Fainting  Smoking History

Low/High Blood Pressure  Raynauds

Heart Condition

Sleeping Problems  Chest Pain Cough

Pacemaker

Vision Difficulties

History of Cancer  Swallowing Difficulties

Allergies to tape/latex  Slurred Speech

Any Allergies

Memory Problems

Epilepsy/Seizures

Balance Problems

Shortness of Breath

Recent Falls/Blackouts

Asthma

Unexplained Weight Loss

Bronchitis

Groin Numbness/Tingling

Respiratory Condition Bowel/Bladder Difficulties

Hearing Impairment  Headaches

Pregnancy

Blood Diseases

Metal Implants  Other: Click here to enter text.

**PREVIOUS INJURIES/SURGERY:** Click here to enter text.

Is there anything else we should know about your health? Click here to enter text.

What do you expect/hope to achieve from therapy?Click here to enter text.

Please list any medications you are currently taking:Click here to enter text.

Please **CLICK** Any Test you have underwent in the last 6 months or for your current complaint/condition.

X-rays CT Scan EMG/nerve conduction MRI Bone Density Study Ultrasound

Other (specify)Click here to enter text.

Reactivate Physiotherapy and Massage believes that it is important to establish and maintain clear lines of communication with all parties involved in the successful rehabilitation of your injury. As a result, information relating to your treatment progression and treatment plans may be shared with your physician, case manager, employer and/or third party payer.

I, Click here to enter text.(**please print your name**), do consent to being treated/assessed by Reactivate Physiotherapy and Massage. I hereby authorize the release of my assessment or progress notes, or any other medical information to my: **(Please fill in appropriate names)**

**Lawyer:** Click here to enter text. **Family Physician/Specialist:**Click here to enter text.

**Insurance Company:**Click here to enter text. **Physiotherapist/Other Medical:**Click here to enter text.

**WSIB/MVA Adjuster:**Click here to enter text. **Employer Representative/Other:**Click here to enter text.

**Or,  I accept responsibility that my report is taken to the appropriate appointment**

**Consent to Treatment**

**Signature/Acknowledgement:** Click here to enter text. **Date:** Click here to enter a date.

HOW DID YOU HEAR ABOUT REACTIVATE PHYSIOTHERAPY & MASSAGE?

Click here to enter text.

**Payment**

**Please check the appropriate box for payment options. (*Initial assessments must be paid for at the time of your first visit)*!**

***Please note that Reactivate Physiotherapy and Massage are able to directly bill to most insurance companies (some restrictions may apply).***

**I would like to pay after each treatment**

**I would like to pay at the end of each week**

**I would like Reactivate Physiotherapy and Massage to directly bill to my insurance company. Insurance company name:** Click here to enter text.

**This is a WSIB Claim**

**This is an MVA Claim *\*\*NOTE: IF THE OCF-1 IS NOT COMPLETED AND RETURNED TO YOUR CAR INSURANCE COMPANY, YOU WILL BE RESPONSIBLE FOR ALL FEES\*\* We will be happy to assist you with the completion of this paperwork. Please just ask ☺***

**Cancellation/No Show Policy**

**Our office requires 24 hours notice of any appointment cancellation. If you do not show for your appointment you may be subject to a $20.00 “No Show” fee.**

**Signature:**Click here to enter text. **Date:** Click here to enter a date.

**We accept the following methods of payment:**

**VISA  
MASTERCARD  
DEBIT  
CHEQUE  
CASH**

**E-TRANSFER**