780-690-3276
cathy@reflectivept.com

CLIENT INTAKE FORM

INFORMATION

Last Name: ______________________ First Name: ______________________
Date of Birth: ______________ Age: ______________ Sex: F ☐M☐
Address: ____
Street or PO Box City Province Postal Code
Occupation: ______________________ Email: ______________________
Phone: ______________________ Cell: ______________________
Emergency Contact Name: ______________________
Relationship: ______________________ Phone: ______________________

How did you hear about Reflective Physical Therapy Inc.? ______________________
Were you in a motor vehicle accident? Yes ☐ No☐
Date of accident: ______________________
Do you have extended health benefits that cover physiotherapy? Yes☐ No☐
Provider Name: ______________________
Policy # and Member ID: ______________________
Insurer's Date of Birth: ______________________

CONSENT FOR ASSESSMENT AND TREATMENT

It is the policy of Reflective Physical Therapy that the therapist explains treatment benefits, side effects and potential complications of assessment and treatment techniques or modalities. Physical therapy treatment may include, but is not limited to: manual techniques, electrical modalities, hot or cold therapy, exercise and acupuncture (needles or needle-less). A number of these may be recommended during your program. Pelvic health treatment may include internal assessment and treatment. Throughout your program if you have any questions or concerns about any recommended treatment or assessment you must inform your therapist immediately so they can explain the treatment rationale and/or modify your program appropriately. If at any time you choose not to participate in the program or any portion of it, you must inform your Physical Therapist immediately. I understand and agree with the criteria above and as such agree to participate in an assessment and treatment program at Reflective Physical Therapy. I understand that for the duration of my treatment, my consent may be withdrawn at any time and understand that I must inform my physiotherapist immediately. _______ Initial

PAYMENT AGREEMENT

I understand that payment for services received at Reflective Physical Therapy Inc. are my responsibility. If my claim is submitted directly to a payor (extended health care benefits) for payment but the payor denies the claim and/or refuses to pay all or any of the full amount billed, I am responsible for paying the amount. I understand the fees per visit and they have been explained to me.

_______ Initial

CONSENT FOR COMMUNICATION

Reflective Physical Therapy Inc. corresponds via electronic format (including but not limited to emails and text message) for convenience, expediency and to maintain a written record. By signing this agreement, you agree that we may communicate with you electronically and you waive any and all rights to find us liable for any disclosure of person or confidential information resulting from the use of email or text message including but not limited to direction to an incorrect party in error, or due to “hacking” or any other form of unauthorized access. _______ Initial

CANCELLATION/MISSED APPOINTMENT POLICY

I understand that if I fail to provide a minimum of 24-hrs notice in advance of a cancellation, I will be charged $95.00 for a late cancellation or missed appointment. This amount is to be paid before any further treatment can be booked. I understand that I will not be penalized for cancellations with more than 24-hr notice. _______ Initial

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MEDICAL HISTORY

Physician:_____________________________ Has your physician seen you for this condition? Yes ☐ No☐

Surgical History & Injury History: List ALL surgeries including dates and ALL previous injuries including dates

____

____

Medication: Please list current prescription medication, vitamins/herbs and over the counter drugs

____

____

Are you aware of your diagnosis & reason for treatment? Yes ☐ No☐

What are your goals/expectations of treatment?

____

____

Current physical activites/stress reducing activites:

____

____

Have you received any treatments from other health care professionals for your current or related problem? (list):

____

Have you ever had physical therapy before? (if yes, please describe reason and dates)

____

Do you have a personal history of any of the following medical conditions? Check answer in box					
	Yes	No		Yes	No
Arthritis – List type:			Neurological Condition – Type:		
Cancer – List type:			Migraines		
Hearing Problems			Bladder Problems		
Asthma			Bleeding Disorder		
Epilepsy/seizures			Bowel Problems		
Vision Problems			Circulation Problems		
Allergies (including nuts/oils)			Depression/Anxiety/Mental Disorders		
Respiratory Problems			Digestive Disorder		
High Blood Pressure			Low Blood Pressure		
History of Stroke			Smoker		
Diabetes			Nausea		
Cardiac Pacemaker			Metal Implants		
Balance Problems			Recreational Drug Use		
Dizziness			Sexual Dysfunction		
Hernia – List type:			**Women only for the following:**		
Cardiac Problems			Menstrual Problems		
Infectious Diseases (including STD's)			Menopausal Problems		
Vomiting			Are you pregnant?		

I have read, understood, and had opportunity to discuss the criteria above. As such, I agree to the above-mentioned terms.

____ ____________________

Signed(If patient under age 18, guardian must sign for them) Date

____ ____________________

Therapist Signature Date