130-33 Victoria St
Toronto, ON M5C 2A1
t: 416-368-2525 f: 1-888-401-3210
info@physiohealthstudios.com
www.physiohealthstudios.com

PATIENT INFORMATION (please complete all of the fields below)				
How did you hear about us?				
Last Name	First Name		Intl.	
Street Address			Home Phone	
City/Town	Province	Postal Code	Work Phone	
Date of Birth (dd/mm/yyyy)	Gender M F		Cell Phone	
Email				
Occupation				
Family Doctor			Family Doctor Phone	
Name of Emergency Contact	Relationship		Phone	

CASE INFORMATION and MEDICAL HISTORY			
Chief complaint/reason for visit			
Musculoskeletal ○ Sprain/strain_____ ○ Injury_____ ○ Arthritis ○ Artificial joints ○ Internal pins/metal ○ Osteoporosis	**Respiratory** ○ Chronic cough ○ Shortness of breath ○ Bronchitis ○ Asthma ○ Emphysema Family history? Y N	**Head and Neck** ○ Headaches ○ Migraines ○ Hearing loss ○ Vision problems ○ Dizziness ○ Vertigo ○ Nausea	**Infections** ○ Hepatitis ○ Skin conditions ○ TB ○ Warts ○ HIV ○ Herpes
Other medical conditions ○ Loss of sensation Where?_____ ○ Epilepsy ○ Cancer ○ Allergy to _____ Reaction:_____ ○ Digestive ○ Haemophilia ○ Urinary ○ Diabetes - onset_____	**Current medications:** **Surgeries:** Date:_____ Nature:_____ Date:_____ Nature:_____	**Cardiovascular** ○ High blood pressure ○ Low blood pressure ○ Heart attack ○ CCHF ○ Stroke/CVA ○ Pacemaker or device ○ Heart disease ○ Phlebitis/varicose veins Family History? Y N	Smoker? Y N **WOMEN:** Pregnant: Y N Due date:_____ Gynecological conditions:_____ _____

To the best of my knowledge I certify that the information provided above is correct and true.

Sign _____ Date_____

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CONSENT FOR EXAMINATION, TREATMENT AND RELEASE OF PATIENT INFORMATION

I, the undersigned, do hereby consent to examination/treatment at Physiohealth Studios, which may include modalities being electrical, ultrasound, orthotic therapy, or manual therapy as well as flexibility and strength training exercises.

Personal health information on this form is collected under the authority of Ontario's Personal Health Information Protection Act, 2004 (PHIPA) for the purposes of providing services to you. We collect only personal health information that we need to provide services to you, as allowed under applicable privacy legislation, and for administrative purposes within Physiohealth Studios. In addition to this intake questionnaire, we may also ask for your consent to collect information from other professionals with whom you are presently or have been previously involved. We will hold this information in confidence and will not disclose your personal health information to anyone outside Physiohealth Studios, other than those persons or organizations indicated.

Some therapeutic techniques are contraindicated under certain conditions. I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

*** CANCELLATION POLICY – PLEASE READ***

*Less than **24 hour cancellation notice** will result in the **FULL appointment fee** being charged. **MISSED APPOINTMENTS or NO SHOWS are subject to the full appointment fee.***

Physiohealth Studios is NOT responsible for appointment reminders. Email reminders are a courtesy only and may not always be delivered.

I have read and fully understood the cancellation policy. Initial here: ☐

I understand and agree to all of the above.

_____	_____	_____
Name (Please Print)	Signature	Date