KGC THERAPY PHYSIOTHERAPY — PATIENT INTAKE FORM

PATIENT NUMBER

DATE

PERSONAL INFORMATION

☐ MR ☐ MS ☐ DR

FIRST NAME | **INT** | **LAST NAME** | **HOME PHONE**

STREET NUMBER AND NAME | **WORK PHONE** | EXT

CITY | **POSTAL CODE** | **COUNTRY** | **CELL PHONE**

DATE OF BIRTH (DD / MM / YY) | **AGE** | **EMERGENCY CONTACT** | **RELATION** | **EMERGENCY PHONE**

EMAIL (OPTIONAL)

MARITAL STATUS
☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SEP

EMPLOYMENT INFORMATION

EMPLOYER | **CAN WE CALL YOU AT WORK** ☐ YES ☐ NO

EMPLOYER ADDRESS | **EMPLOYER CITY** | **EMPLOYER P/C**

EXTENDED HEALTH CARE INFORMATION

EXTENDED HEALTH CARE COMPANY | **GROUP NUMBER** | **POLICY NUMBER/ID NUMBER**

REFERRING PHYSICIAN INFORMATION

SPECIALIST PHYSICIAN | **PHONE NUMBER (IF KNOWN)-1**

FAMILY PHYSICIAN INFORMATION

FAMILY PHYSICIAN | **PHONE NUMBER (IF KNOWN)**

WSIB/MOTOR VEHICLE ACCIDENT CLAIMS (ONLY COMPLETE IF IT APPLIES)

ARE YOU MAKING A CLAIM FOR:
☐ MOTOR VEHICLE ACCIDENT ☐ WSIB (WORKPLACE ACCIDENT)

HAVE YOU INJURED THIS AREA BEFORE?
☐ YES ☐ NO

HEALTH CARD (OHIP) NUMBER | **VER NO**

EXPIRY DATE (DD/MM/YYYY)

DATE OF ACCIDENT | **CLAIM NUMBER (IF KNOWN)**

BRIEFLY DESCIBE WHAT HAPPENED

PLEASE COMPLETE BELOW

FAMILY HISTORY OF DISEASE			
CANCER	YES	NO	
STROKE	YES	NO	
DIABETES	YES	NO	
HYPERTENSION	YES	NO	
YOUR HISTORY			
ANEURYSM	YES	NO	
STROKE	YES	NO	
EPILEPSY	YES	NO	
HEART	YES	NO	
OSTEOPOROSIS	YES	NO	
BONE	YES	NO	
DIABETES	YES	NO	
CANCER	YES	NO	
BLOOD CLOTS	YES	NO	
BLEEDING	YES	NO	
HIGH/LOW BP	YES	NO	
ARTHRITIS	YES	NO	
NEUROLOGICAL	YES	NO	
DIZZINESS	YES	NO	
HEADACHES	YES	NO	
HIV POSITIVE	YES	NO	
PREGNANCY	YES	NO	
LIFE STYLE			
DO YOU SMOKE	YES	NO	
BIRTH CONTROL	YES	NO	
PLEASE LIST ALL THE SURGERIES YOU HAVE HAD IN THE PAST			
PLEASE LIST ANY MEDICATION/ VITAMINS YOU ARE CURRENTLY TAKING			

PLEASE TURN PAGE OVER

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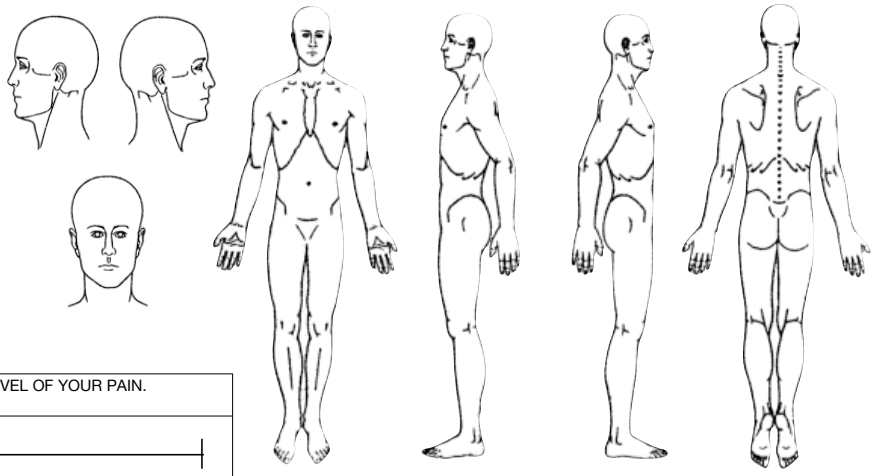
CHIEF COMPLAINT

PLEASE COMPLETE THE FOLLOWING

STEP 1

ON THE BODY TO THE RIGHT, USING THE SYMBOLS BELOW, PLEASE MARK THE LOCATION OF YOUR PRIMARY COMPLAINT

ACHE	BURNING	NUMBNESS	TINGLING	STABBING /SHARP	DEEP
XXXXX	++++++	^^^^^^	*********	/////////	----------



STEP 2

	HOW DID YOUR SYMPTOMS START?		**WHEN** DID YOUR SYMPTOMS START
	SUDDEN		0-3 MONTHS
	GRADUAL		3-6 MONTHS
	CAR ACCIDENT		6-9 MONTHS
	WORK RELATED INJURY		1 YEAR OR MORE

STEP 3

IF YOUR DISCOMFORT IS PAIN, PLEASE MARK ON THE LINE BELOW, THE LEVEL OF YOUR PAIN.

0 (NO PAIN) — WORSE PAIN (10)

OFFICE POLICIES

SCHEDULING

1 Appointments during regular hours must be scheduled to reduce patient waiting time.
2 Drops in are welcome, however all scheduled appointments will be seen first
3 Cancellations require 12 hours notice to make the appointment available to other patients.

PAYMENT

1 Payment is expected in full each visit, we accept Cash, Cheque, Interac Debit Card, and Visa
2 NSF Cheques will be charged a $15.00 fee
3 Should you discontinue care for any reason, any outstanding balance will become due immediately and payable in full by you.

FEES

1 The fee is payable in full at each visit
2 Patients with health insurance plans, typically part of an employee benefit package are allowed to claim their patient fee for chiropractic services through their insurer.

FEE SCHEDULE

ADULT PATIENT	**FEE**
INITIAL CONSULTATION	**$85.00**
SUBSEQUENT VISIT	**$65.00**
UNDER 18	
INITIAL CONSULTATION	**$85.00**
SUBSEQUENT VISIT	**$65.00**

INFORMED CONSENT TO RELEASE MEDICAL INFORMATION

I authorize any duly authorized representative of KGC Therapy

- ☐ To obtain copies of my medical records concerning any injury or illness related to my condition being treated
- ☐ Discuss and provide reports to my family physician, specialist, or surgeon
- ☐ Discuss and provide reports to Workman's Compensation Board
- ☐ Discuss and provide reports to my employer
- ☐ Discuss and provide reports to_____

A photocopy of this authorization may be accepted with the same authority as the original.

I have reviewed the above information that explains how your office will use my personal information and the steps your office is taking to protect my information.

I know that your office has a Privacy Code and I can ask to see the Code at any time.

I consent to receiving treatment at KGC Therapy as outlined by my treating Physiotherapist(s).

_____
NAME (PLEASE PRINT)

_____ DATED _____ 20____ _____
SIGNATURE — SIGNATURE OF WITNESS