Physicentrix
RÉADAPTATION PHYSIQUE ET BIEN-ÊTRE
PHYSICAL REHABILITATION AND WELLNESS

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Client Registration Form

Please use CAPITAL LETTERS and print clearly, thank you

Title ☐☐☐☐ ☐ **Male** ☐ **Female**

Surname

First name

Date of birth (D/M/Y) ☐☐ / ☐☐ / ☐☐☐☐

Postal address **Apt.**

City / Postal Code /

Email

Telephone (Home) **(Work)**

Mobile

Occupation **Company**

Your Doctor's Name **Telephone**

Doctor's Address

Do you give permission for us to send a letter to your doctor confirming that you have commenced treatment? ☐ Yes ☐ No

Do you consent for us to send you electronic communications (you may change this consent at any time)? ☐ Yes ☐ No

1. Who referred you to this clinic?____

2. Do you have private health insurance? (circle) **YES / NO** **3. If yes, company:** ________________

4. How did you find out about this clinic? (Please tick an option below)

☐ Internet Search ☐ Our Website ☐ Workplace ☐ Directory Assist ☐ Yellow Pages
☐ Poster / Advert ☐ Brochure / Flyer ☐ Lecture/Course ☐ Clinic Desk ☐ Gym
☐ From my Doctor ☐ A Friend: ________________________________
☐ From my Trainer ☐ Other:__________________________________

5. Do you have a Personal Trainer?

☐ Yes ☐ No Name:_____________________________

6. Which sports do you practice, if any?____

7. In which part(s) of the body is the pain/injury located?____

8. Are you claiming through CSST or SAAQ? ☐ Yes (complete details) ☐ No (go to 9)

Claim No:_______________ Date of Injury:______/______/2017 Insurer:______________ Case Manager: __________

9. Have you seen another therapist before? ☐ Yes ☐ No

10. If yes, is there anything you were not happy about?____

11. If yes, what aspects were you most happy with?____

12. What are the TWO main things you would like to achieve by the end of today's session?

a) ____ b) ____

13. Why is it important to you that you get rid of your injury/ problem as soon as possible?

____

14. Medical History (Check ALL that apply):

List of **medications** that you are taking now:____

☐ Allergies, including medications:____

☐ Skin Condition
☐ Hepatitis or HIV
☐ Tuberculosis
☐ Seizures
☐ Headaches
☐ Mental Illness
☐ Arthrosis/Arthritis/Rheumatism
☐ Screws, implants or plates
☐ Surgeries:

☐ Cold Hypersensitivity
☐ Cholesterol
☐ Hypertension
☐ Pacemaker
☐ Heart problems
☐ Anemia
☐ Urinary tract problem
☐ Dizziness
☐ Depression

☐ Phlebitis/Deep vein thrombosis
☐ Pregnant
☐ Digestive problems
☐ Fibromyalgia/Osteoporosis
☐ Recent weight gain/loss
☐ Lung problem
☐ Infectious disease
☐ Diabetes
☐ Dizziness

☐ Cancer, since?:_____ Type:_________________ Treatment received:___________________________

☐ Other:____

Habits: ☐ Alcohol (___times/week) ☐ Cigarette (__/day) ☐ Drugs ☐ Other:_______________

15. Foot Care

☐ Sore feet
☐ Heel Pain
☐ Visible foot problem (bunions/ fallen arches/calluses
☐ Play sports regularly
☐ Joint pain while walking/running (ankle/knee/hip/back)

☐ Over 40yrs old
☐ Overweight
☐ Regular standing/walking
☐ While walking do your feet "toe-in/toe-out"
☐ Family history of foot problems

INFORMED CONSENT FOR TREATMENT

Please carefully read and sign this form prior to your treatment.
Please address any questions/concerns regarding the below items with your therapist

I hereby acknowledge and understand that I will be responsible for payment of accounts for any and all services received. SAAQ or CNESST claims are paid by those insurance plans, however, should these claims not be approved for any reason I will also be responsible for payment of accounts for any and all services received as part of any of these claims.

I understand that should I cancel or not attend a scheduled appointment without providing **48 hours' notice** that the **full appointment fee will be charged**. Not attending an appointment is an inconvenience to the clinic, our other patients (who may be waiting for an appointment to become available), and generally means you require more treatment to recover.

I understand that my therapist will discuss treatment options with me prior to delivery of my care and that my treatment plan may include education, therapy, modalities and active exercise.

I understand that my therapist may recommend a product (ie knee brace, orthotics) to accelerate my recovery or improve my general health condition. Your therapist may have a financial interest on certain products. However, you may choose to purchase this product elsewhere should you wish.

I understand that there may be risks if I do not disclose my full health history or any change pertaining to my health condition (medical diagnosis or other diagnosis, change of medication, or any other health-related intervention), as I acknowledge that those changes may require an adaptation of the care that I will receive. I understand that my therapist will educate me on the acceptable pain levels, expectations and management during my care/recovery. My healthcare practitioner has informed me of the risks, although low, of treatment complications. Some patients may feel muscular soreness, temporary stiffness or a slight and temporary aggravation of their symptoms. Also, I appreciate that while rare; fractures, strains, sprains, bruising or burns may result from my treatment.

I have had the opportunity to discuss the benefits and risks of treatment for my current situation and I understand the consequences of not complying with the prescribed treatment may include no change in my signs or symptoms, delayed recovery and/or not achieving my health goals.

I understand that a support personnel (i.e., Massage Therapist, Kinesiologist, Athletic Therapist, etc) may assist my therapist in delivery of my care. I understand that support personnel are following the plan that has been developed and directed by my therapist. I understand that students may assist my therapist in the delivery of my care and that they are under his/her supervision.

I understand that the therapist develops, monitors and alters my treatment as indicated and that he/she will communicate with my affiliated physicians/specialists or other parties within the clinic as needed.

I acknowledge having read this consent form, and having understood all information included therein. I hereby consent to receive care at Physicentrix and that I may withdraw my consent at any time upon written notice.

Client Signature: ____ Date: ____________________