Keenan Health Centre | 303 Harmer Ave S., Ottawa ON K1Y 3B3 | 613-728-9414 | www.ottawahealth.ca
Chantal Goneau, PT | Jamie Emery, PT

Physiotherapy Intake Form

Personal Contact Information

Name _____

Address _____ City _____ Prov _____

Postal Code _____ Email _____

Phone: (Home) _____ (Cell) _____ (Work) _____

DOB _____ / _____ / _____ Age _____ Gender M ☐ F ☐ O ☐
Year Month Day

How did you hear about us? _____

Employment Information

Occupation _____ Employer _____

Employer's Address _____ City _____

Emergency Contact Information

Emergency Contact _____ Phone _____
Name Relation

Family Physician _____ Phone _____

Patient Advisement of Purpose of Collection of Health Information

Please be advised the registration information collected will be used for creating a patient file and for billing purposes. The information is being collected under the authority of *Health Information Act*. The provisions of the *Health Information Act* protect your privacy and the confidentiality of your health information. The *Health Information Act* provides for sharing of patient information between healthcare providers when said sharing contributes to the continuing care and treatment of the patient.

Please be advised the clinic may need to contact you in regards to your appointments. From time to time, we may need to leave messages and ask that the phone number you provide may be used for this purpose.

Appointments: Should be made in advance, clients are expected to attend and arrive on time for all scheduled appointments. Clients are required to provide **48 hours' notice** to cancel or change an appointment, **or a full fee will be charged.**

Fees: Are based on a single injury / condition, additional charges will be applied for multiple injuries / conditions. Payment is due upon receipt. We accept Visa, MasterCard, Debit card, cheque and cash.

Insurance: Our services are covered by Extended Health Care Plans, MVA Insurances and WSIB.

YOU ARE FULLY RESPONSIBLE FOR THE COST OF YOUR TREATMENTS REGARDLESS OF HOW MUCH YOUR INSURANCE MAY COVER.

Patient Signature _____ Print Name _____ Date: ____/____/_____
If under 16 years of age, must be signed by parent/guardian Y M D

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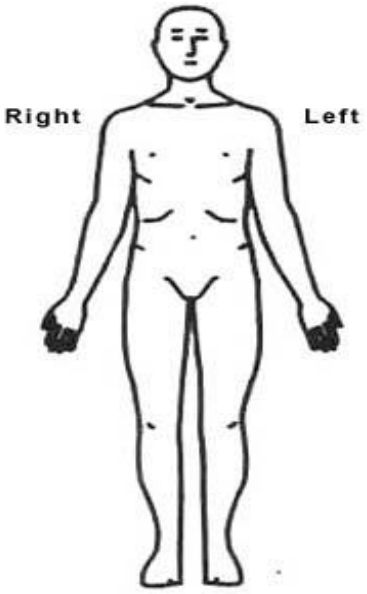

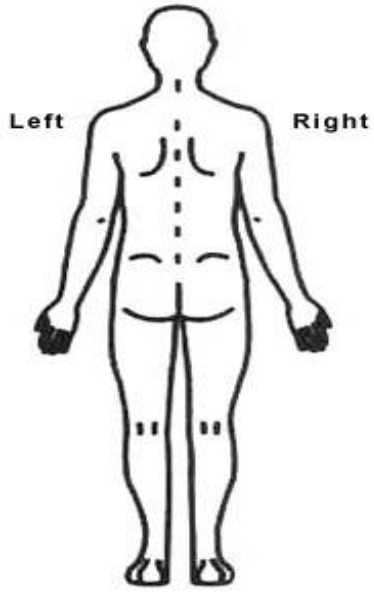

Please shade in on the bodies to indicate areas of pain, discomfort and concern. Feel free to add brief text description.

Please indicate any old injuries (“O”), numbness (“N”), tingling (“T”) and burning (“B”) with the appropriate symbol on the drawings.

Please indicate if any of the following apply:

☐ High blood pressure

☐ Low blood pressure

☐ Heart trouble

☐ Phlebitis / Varicose veins

☐ Stroke / CVA

☐ Pacemaker

☐ Chronic cough / Bronchitis

☐ Shortness of breath

☐ Arthritis

☐ Asthma

☐ Emphysema

☐ Diabetes

☐ Allergies

☐ Epilepsy

☐ Is there a family history of the above? _____

☐ Treatment from another health care provider?

_____

☐ Hepatitis

☐ History of headaches

☐ TB

☐ HIV

☐ Herpes

☐ Loss of sensation

_____

☐ Skin Conditions

_____

☐ History of migraines

☐ Vision problems

☐ Vision loss

☐ Women if pregnant, Due date

_____

☐ Gynecological conditions

_____

☐ Surgery date & nature

_____

☐ Injury date & nature

_____

☐ Ear problems

☐ Hearing loss

☐ Do you have internal pins, wires, artificial joints, equipment?
What

_____

Where

_____

☐ Do you have any other medical conditions?

_____

☐ What is the reason for seeking help?

_____

☐ Overall, how is your health?

_____

☐ Medications

_____

_____

☐ Conditions

_____

_____

Patient Signature _____ Print Name _____ Date: ____/____/_____
If under 16 years of age, must be signed by parent/guardian
Y M D