Physiotherapy

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2 Orchard Heights Boulevard Suite #36, Aurora, ON L4G 3W3
P: 905.713.2427 | F: 905.713.2910 | E: info@lifespringclinics.ca

CLIENT INFORMATION SHEET

DATE: ______________________________ GENDER (circle one) M / F / X

CLIENT NAME: ____
(LAST) (FIRST)

CLIENT's D.O.B. (DD/MM/YYYY): _____/_____/_____

PLEASE CHECK PREFERRED CONTACT #

HOME ADDRESS: ______________________________ ☐ HOME PHONE: ______________________

TOWN/CITY: ______________________________ ☐ WORK PHONE: ______________________

POSTAL CODE: ______________________________ ☐ CELL PHONE: ______________________

E-MAIL: ______________________________ PREFER NO EMAIL ☐

FAMILY PHYSICIAN: ______________________________ PHONE: ______________________

REFERRAL SOURCE / NAME: ______________________________

IN THE EVENT OF AN EMERGENCY, PLEASE CONTACT:

______________________	______________________	______________________
EMERGENCY CONTACT NAME	RELATIONSHIP	EMERGENCY PHONE NUMBER

IS YOUR INJURY: ☐ WORK RELATED ☐ MOTOR VEHICLE ACCIDENT ☐ SPORT ☐ OTHER: ____________

We are interested in knowing all the ways you may have heard of Lifespring. Please **CHECK** any of the following that apply:

☐ INTERNET SEARCH ☐ SOCIAL MEDIA ☐ DOCTOR
☐ CLIENT REFERRAL ☐ RETURNING CLIENT ☐ OTHER __________________

CONSENT FOR ASSESSMENT:

- I understand that a Registered Physiotherapist will be performing my assessment and will discuss treatment with me.
- I consent that all personal information on these forms is accurate and up to date.
- I understand that the Director of LifeSpring Physiotherapy is the Health Information Custodian of my records.
- I have read the Patient Privacy Information Sheet and agree to LifeSpring's policies as outlined.
- I agree to pay for services rendered at LifeSpring Physiotherapy.

☐ I authorize LifeSpring to discuss or release my medical information with or to my doctor or health care professional(s), insurance company, employer or their representative(s) about my assessment, treatment and progress.

CLIENT / GUARDIAN SIGNATURE: ______________________________________

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HEALTH INFORMATION QUESTIONNAIRE

Name: ______________________________ Date: ____________________

Patient's D.O.B. (day/month/year): ____/____/______

Please complete this form to ensure optimum care. All information will remain confidential and be part of your physiotherapy records.

	YES	NO
1. Do you have a history of heart disease or chest pain?	☐	☐
2. Do you often feel faint or have spells of severe dizziness?	☐	☐
3. Do you have hypertension (high blood pressure)?	☐	☐
4. Do you have diabetes?	☐	☐
5. Do you have a pacemaker?	☐	☐
6. Do you have epilepsy/seizures?	☐	☐
7. Do you have asthma or other respiratory conditions?	☐	☐
8. Do you have any allergies/sensitivities to tape, creams, cold? If so, please list: ________	☐	☐
9. Are you pregnant?	☐	☐
10. Do you smoke?	☐	☐
11. Do you have Osteoporosis?	☐	☐
12. Have you ever had cancer? If so, please explain: ________	☐	☐
13. Have you had any major surgeries or serious illness? If so, please explain: ________	☐	☐
14. Are you taking any medication? If so, please list: ________	☐	☐
15. Do you have any bleeding disorders?	☐	☐
16. Do you have any metal in your body? (eg. jt. replacement, pins/plates/screws, IUD, hearing aid)	☐	☐
17. Have you had any recent x-rays or scans during the past year?	☐	☐
18. Are you receiving any other treatment at present?	☐	☐
19. Have you had physiotherapy previously? If so, when? ________ for what reason? ________	☐	☐
20. Is there any known medical reason that you are currently unable to participate in exercise?	☐	☐
21. Is there anything else about your health that we should be aware of? Please list details: ________	☐	☐

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TWENTY-FOUR HOUR CANCELLATION POLICY

FOR PHYSIOTHERAPY & MASSAGE THERAPY CLIENTS

We value each of you as individuals and welcome the responsibility and privilege of caring for and supporting you, as health care professionals.

Our goal is for each client to be seen and treated in a timely and efficient manner. With that as our focus, we want to remind everyone of our Clinic policy concerning cancelled appointments.

For Physiotherapy Clients:

There will be a standard appointment fee of $25.00 applied to your account for any missed appointments or for any cancellations received without 24 hour notification. We do have voice mail and email which we check regularly so a message can be left at any time of the day or night.

For Massage Therapy and MVA Clients:

There will be a standard missed appointment fee applied to your account for any missed appointments or cancellations received without 24 hour notification. We do have voice mail and email which we check regularly so a message can be left at any time of the day or night. For MVA Clients, it is your responsibility to cover any MAP charges personally.

Massage Therapy 60 min: $89.00
MVA Physio 30 min. $25.00
MVA Physio 60 min. $40.00

We appreciate your patronage and look forward to treating you in a timely and efficient manner.

Yours professionally,

Ron O'Hare and the LifeSpring Staff

(*) I have read and agree to this cancellation policy.

Name: ______________________________ Date: ______________________
Please print

Patient's D.O.B.(day/month/year): ___/___/_____

Signed: ______________________________