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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): _____/_____/______ I give permission for electronic communication. ☐ Y ☐ N

HOME ADDRESS: ______________________________ ☐ HOME PHONE: ____________________

TOWN/CITY: ______________________________ ☐ CELL PHONE: ____________________

POSTAL CODE: ______________________________ I PREFER NO TEXTS ☐

E-MAIL: ______________________________ I PREFER NO EMAILS ☐

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 & the recommended treatment plan 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: ______	☐	☐