

**PERSONAL INFORMATION:**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: M \_\_\_\_\_ /D \_\_\_\_\_ /Y \_\_\_\_\_ Occupation: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: (     ) \_\_\_\_\_

Cell: (     ) \_\_\_\_\_ Work: (     ) \_\_\_\_\_

Email Address: \_\_\_\_\_

Family Doctor: \_\_\_\_\_

Tel: (     ) \_\_\_\_\_ Fax# (     ) \_\_\_\_\_

Family Dr. Address Or Location:  
\_\_\_\_\_

Referring Physician: \_\_\_\_\_ (If Different From Family Doctor)

Address Or Location:  
\_\_\_\_\_

**Reason for your visit today:**  
\_\_\_\_\_

**Goals of treatment you would like to achieve:**  
\_\_\_\_\_

**HOW DID YOU FIND OUT ABOUT US?**

- |                                                       |                                                  |                                       |
|-------------------------------------------------------|--------------------------------------------------|---------------------------------------|
| <input type="checkbox"/> Dr. Referral                 | <input type="checkbox"/> A Friend _____          |                                       |
| <input type="checkbox"/> Internet                     | <input type="checkbox"/> Sign Outside            |                                       |
| <input type="checkbox"/> Returning Patient            | <input type="checkbox"/> Village Voice           | <input type="checkbox"/> Website      |
| <input type="checkbox"/> Advertisement                | <input type="checkbox"/> Phone Book/Yellow Pages | <input type="checkbox"/> Social Media |
| <input type="checkbox"/> Other (Please Specify) _____ |                                                  |                                       |

**May we send you information regarding Newcastle Village Physiotherapy?**

**By mail: Yes \_\_\_\_\_ No \_\_\_\_\_      By e-mail: Yes \_\_\_\_\_ No \_\_\_\_\_**

**EMERGENCY CONTACT:**

Name: \_\_\_\_\_ Tel#: (     ) \_\_\_\_\_ Relationship: \_\_\_\_\_

**HEALTH INFORMATION:**

**Please list any surgeries or procedures (please include any internal pins/wires/artificial joints) you have had done recently or in the past:**

Surgery/Procedure \_\_\_\_\_ Date: \_\_\_\_\_  
 Surgery/Procedure \_\_\_\_\_ Date: \_\_\_\_\_

**Medication(s) you are currently taking:** (we can photocopy medication list if you carry one with you)

\_\_\_\_\_  
 \_\_\_\_\_

**Allergies:**

\_\_\_\_\_

**Do you currently have or have you ever experienced any of the following?  
 Please check all that apply:**

<b><u>Respiratory</u></b>	<b><u>Infections</u></b>	<b><u>Other Conditions</u></b>
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> TB	<input type="checkbox"/> Loss of sensation
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> HIV	<input type="checkbox"/> Cancer
<input type="checkbox"/> Asthma	<input type="checkbox"/> Infectious skin conditions	<input type="checkbox"/> Arthritis
<b><u>Cardiovascular</u></b>	<b><u>Head/Neck</u></b>	type _____
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Vision problems	<input type="checkbox"/> Skin condition
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Ear problems	type _____
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Osteoporosis/Osteopenia
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Headaches / Migraine	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Depression
<input type="checkbox"/> Stroke	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Chronic Fatigue/ Fibromyalgia
<input type="checkbox"/> Pacemaker	<b><u>Pelvic Health</u></b>	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Urinary Incontinence	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Pelvic Pain	<input type="checkbox"/> Other: _____
<b><u>Allergies</u></b>	<input type="checkbox"/> Constipation	<input type="checkbox"/> Other: _____
<input type="checkbox"/> latex	<input type="checkbox"/> Painful Intercourse	<input type="checkbox"/> Other: _____
<input type="checkbox"/> vinyl	<input type="checkbox"/> Pelvic organ prolapse	
<input type="checkbox"/> acupuncture needles		
<input type="checkbox"/> massage lotion/coconut oil		

**Women:** Are you currently pregnant? No \_\_\_\_\_ Yes \_\_\_\_\_, \_\_\_\_\_ weeks  
 Have you recently given birth? No \_\_\_\_\_ Yes \_\_\_\_\_, \_\_\_\_\_ weeks ago

**Consent to Collect, Use and Release information:**

As healthcare practitioners we collect, use, and disclose personal information responsibly and only to the extent necessary for the goods and services we provide.

I hereby consent to Newcastle Village Physiotherapy and its service providers and employees to collect my personal information (name, address, contact information, insurance/billing information, and health information) for the purposes of:

- \* Making decisions regarding my care, treatment and services needed
- \* Scheduling my appointments and contact me regarding appointments
- \* Producing invoices, process credit card payments or collection of unpaid accounts
- \* Reviewing patient files to ensure high quality services, performance assessments and Inspections of records by the College of Physiotherapists in the public interest
- \* Producing reports used by Newcastle Village Physiotherapy for research and statistical Purposes
- \* Meeting legal and regulatory requirements

My information may be shared with/released to: my insurance company, adjuster from my motor vehicle insurance, physician or family doctor and/or other healthcare professionals involved in my care. Your health record cannot be release or transferred without your written consent.

**Date:** \_\_\_\_\_ **Patient/Guardian Signature:** \_\_\_\_\_

**FEE AGREEMENT**

I, \_\_\_\_\_ (Full Name), am fully responsible to Newcastle Village Physiotherapy for payment of my account in full. I understand even if Newcastle Village Physiotherapy is assisting me in making a claim to my insurance company, I am ultimately responsible for all fees incurred at Newcastle Village Physiotherapy. I agree to pay my account in full at the end of each visit. Newcastle Village Physiotherapy will provide me with an invoice after each paid visit, which I can use to forward to my insurance company and/or another third party payer. If it is necessary to cancel an appointment, 24 hours notice is required or a 50% charge will be issued. This charge will also apply for any missed appointments.

**PATIENT/GUARDIAN SIGNATURE:** \_\_\_\_\_

**Date:** \_\_\_\_\_ **WITNESS:** \_\_\_\_\_

**APPOINTMENT REMINDERS:**

- |                                                                                                                                              |                            |
|----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|
| <input type="checkbox"/> I would like to receive a reminder via email                                                                        | <b>Initial here:</b> _____ |
| <input type="checkbox"/> I would like to receive a reminder via a phone call                                                                 | <b>Initial here:</b> _____ |
| <input type="checkbox"/> I do not need to be reminded of my appointments and acknowledge that there is a <b>cancellation/no show fee 50%</b> | <b>Initial here:</b> _____ |