BELMONT CENTRE FOR PHYSICAL MEDICINE

564 Belmont Ave. W., Suite 301, Kitchener, ON N2M 5N6 / Tel. (519) 743-4355 Fax (519) 743-6787

SOS Physiotherapy
Kimberly Rau & Associates Inc.
Registered Massage Therapy
KW Pelvic Health

Rev. Sep.2018

Chart # _____

Today's Date: _____

Gender: Male ❑ Female ❑

PROVIDER – check all that apply (OFFICE USE ONLY):

SOS		KRA Inc.	RMT	OTHER
❑ Jonathon Clay	❑ Amy de Corte	❑ Kimberly Rau	❑ Kimberly Schmidt	❑ Beth Albert (KW Pelvic Health)
❑ David Slover	❑ Stephen Hogan	❑ Patrick Purves	❑ Trinity Hughes	❑ Stacy Foote (KW Pelvic Health)
❑ Andrew Woelk		❑ Kalsey Smith	❑	❑ Chandni Chadha (KW Pelvic Health)
❑ Adam Dafoe		❑ David Stotesbury	❑	❑

PATIENT INTAKE FORM & PRE-ASSESSMENT QUESTIONNAIRE

PLEASE PRINT CLEARLY AND COMPLETE ALL INFORMATION. Our services are not covered by the Ministry of Health (OHIP). If you have an Extended Health Plan, please check this to determine any coverage you may have.

CANCELLATIONS – We respectfully ask that you provide a minimum of 24 hours notice if you must cancel an appointment. A fee of $65.00 will be charged for any late cancellation or no-show appointment.

Verify if there is an Apt. or Unit #.

AFFIX LABEL HERE

How did you hear about us? _____

Email Address: _____

Occupation: _____

Emergency Contact:
Name _____
Daytime Phone # _____

Permanent Address (if different from above) :
Street _____
City/Prov _____
Postal Code _____
Phone # _____

If Patient is a Student/Dependent, please provide the following:
Parent/Guardian Name _____
Relationship to Patient _____
Address (if different from patient):
Street _____
City/Prov _____
Postal Code _____
Phone # _____

Referring Health Care Provider:
Name _____
Street _____
City/Prov _____
Postal Code _____
Phone # _____

Family Physician (if different from Referring Health Care Provider):
Name _____
Street _____
City/Prov _____
Postal Code _____
Phone # _____

Are you attending due to: ❑ Motor Vehicle Accident (MVA) injury ❑ Workplace (WSIB) injury
If you have checked one of the above, please notify the receptionist.

Your Goals for Therapy: _____

Type of Injury/Condition: _____ Onset/Injury Date: _____

Previous Illnesses & Surgeries: _____

Current Medications: _____

CONTINUED ON REVERSE⇨

List Allergies: _____

HEALTH HISTORY (check all that apply):

GENERAL

- ❑ Allergies/Skin Sensitivity
- ❑ Arthritis
- ❑ Autoimmune Deficiency
- ❑ Cancer (specify) _____
- ❑ Circulation Problems
- ❑ Diabetes (circle type) Type 1 Type 2
- ❑ Digestive Disorders
- ❑ Ear Aches
- ❑ Easy Bruising/Bleeding
- ❑ Epilepsy/Seizures
- ❑ Fainting
- ❑ Fracture (location) _____
- ❑ Headaches Type? _____
- ❑ Hearing Loss
- ❑ Hemophilia
- ❑ Hernia
- ❑ Hypoglycemia
- ❑ Indigestion/Heartburn
- ❑ Kidney Disease
- ❑ Loss of Consciousness
- ❑ Loss of Sensation
- ❑ Metal Implant
- ❑ Multiple Sclerosis
- ❑ Osteoporosis/Osteopenia
- ❑ Sprains/Strains (location) _____
- ❑ Thyroid Problems
- ❑ Urinary Problems/Infections
- ❑ Vision Loss
- ❑ Other (explain below)

CARDIOVASCULAR

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Congestive Heart Failure
- ❑ Heart Disease
- ❑ Heart Attack When? _____
- ❑ Stroke When? _____
- ❑ Pacemaker/similar device
- ❑ Varicose Veins

RESPIRATORY

- ❑ Asthma
- ❑ Bronchitis
- ❑ Chronic Cough
- ❑ Emphysema
- ❑ Shortness of Breath

INFECTIOUS CONDITIONS

- ❑ Hepatitis
- ❑ Infectious Skin Condition
- ❑ Tuberculosis

WOMEN

- ❑ Currently Pregnant
- ❑ Number of Pregnancies
- ❑ Gynecological Problems
- ❑ Menopause
- ❑ Painful Menstruation

Other: _____
_____

Please explain & give approximate dates of onset/occurrence of any conditions checked above: _____
_____
_____

Have you had a previous injury that may affect current care? Please describe: _____
_____

Have you had a previous motor vehicle accident injury or workplace injury? ❑ Yes ❑ No
If yes, please give injury date and description : _____
_____

Have you recently noted any of the following? (check all that apply)

❑ Breathing Difficulty	❑ Fever/Chills/Sweats	❑ Night Pain
❑ Change in Vision/Hearing	❑ Headaches	❑ Numbness/Tingling
❑ Dizziness/Light-headedness	❑ Insomnia	❑ Weakness
❑ Fatigue	❑ Nausea/Vomiting	❑ Weight Loss/Gain

PAYMENT INFORMATION & POLICIES:
Payment is generally required after each treatment. There are some exceptions to this requirement (i.e. auto accident, rehabilitation programs, DVA, IFHP, etc.). If you are purchasing custom foot orthotics, payment is not required until orthotics are received. Cash, cheque, debit, Visa, and Mastercard are accepted. Our fee schedule is posted clearly at our reception desk and in the waiting room area, and is subject to change upon posted notice only. Outstanding balances will be charged interest at 2% per annum. On default of payment, all lawyers and/or agents costs of recovering the debt are also payable on a solicitor or agent and its own client basis.

I (print name)_____, hereby state that the above information is accurate and true to the best of my knowledge.

_____ _____
Signature of Patient or Parent/Guardian Date

If Parent/Guardian, please give relationship to patient: _____