

# SOS PHYSIOTHERAPY (ELMIRA)

3 Wyatt St. E., Suite 2, Elmira, ON N3B 2H4 / Tel. (519) 669-1212 Fax (519) 669-0800

Rev. Feb.2015

SOS Physiotherapy  
KW Pelvic Health  
Kimberly Rau & Associates Inc.  
Osteopathy

Chart # (if applicable): \_\_\_\_\_

Today's Date: \_\_\_\_\_

Gender: Male  Female

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

SOS	KW PELVIC HEALTH	KRA Inc.	OSTEOPATH
<input type="checkbox"/> Jonathon Clay	<input type="checkbox"/> Beth Albert	<input type="checkbox"/> Kalsey Smith	<input type="checkbox"/> Lisa Stemmler
<input type="checkbox"/> Amy de Corte	<input type="checkbox"/> Nimmy Thomas	<input type="checkbox"/> Patrick Purves	<input type="checkbox"/>
<input type="checkbox"/> Coco Ang	<input type="checkbox"/> Soodeh Amjadi		
<input type="checkbox"/> Melissa Norris			

## 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.**

Name: _____	
Date of Birth: _____	YYYY _____ MM _____ DD _____
Address: (please give Apt. or Unit # if applicable)	
Street	_____
City/Prov	_____
Postal Code	_____
Phone-Home	_____
Phone-Work	_____ x _____
Phone-Cell	_____

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):**

<p><b>GENERAL</b></p> <input type="checkbox"/> Allergies/Skin Sensitivity <input type="checkbox"/> Arthritis <input type="checkbox"/> Autoimmune Deficiency <input type="checkbox"/> Cancer (specify) _____ <input type="checkbox"/> Circulation Problems <input type="checkbox"/> Diabetes (circle type) Type 1    Type 2 <input type="checkbox"/> Digestive Disorders <input type="checkbox"/> Ear Aches <input type="checkbox"/> Easy Bruising/Bleeding <input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Fainting <input type="checkbox"/> Fracture (location) _____ <input type="checkbox"/> Headaches Type? _____	<input type="checkbox"/> Hearing Loss <input type="checkbox"/> Hemophilia <input type="checkbox"/> Hernia <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Indigestion/Heartburn <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Loss of Sensation <input type="checkbox"/> Metal Implant <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Osteoporosis/Osteopenia <input type="checkbox"/> Sprains/Strains (location) _____ <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Urinary Problems/Infections <input type="checkbox"/> Vision Loss <input type="checkbox"/> Other (explain below) _____	<p><b>CARDIOVASCULAR</b></p> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Heart Attack When? _____ <input type="checkbox"/> Stroke When? _____ <input type="checkbox"/> Pacemaker/similar device <input type="checkbox"/> Varicose Veins	<p><b>RESPIRATORY</b></p> <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Emphysema <input type="checkbox"/> Shortness of Breath	<p><b>WOMEN</b></p> <input type="checkbox"/> Currently Pregnant <input type="checkbox"/> Number of Pregnancies <input type="checkbox"/> Gynecological Problems <input type="checkbox"/> Menopause <input type="checkbox"/> Painful Menstruation
		<p><b>INFECTIOUS CONDITIONS</b></p> <input type="checkbox"/> Hepatitis <input type="checkbox"/> Infectious Skin Condition <input type="checkbox"/> Tuberculosis		

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)

<input type="checkbox"/> Breathing Difficulty <input type="checkbox"/> Change in Vision/Hearing <input type="checkbox"/> Dizziness/Light-headedness <input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever/Chills/Sweats <input type="checkbox"/> Headaches <input type="checkbox"/> Insomnia <input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Night Pain <input type="checkbox"/> Numbness/Tingling <input type="checkbox"/> Weakness <input type="checkbox"/> Weight Loss/Gain
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**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: \_\_\_\_\_