Please select your clinic location.

○ **SOS BELMONT**
Kimberley Rau & Associates Inc.
Registered Massage Therapists
Belmont Professional Centre
564 Belmont Avenue West, Suite 301
Kitchener, Ontario N2M 5N6
Tel: (519) 743-8787 / Fax: (519) 743-6787
Email: belmont@sosphysiotherapy.ca

○ **SOS NORTHFIELD**
Waterloo Corporate Campus
Sobeys Plaza
595 Parkside Drive, Suite 5A
Waterloo, Ontario N2L 0C7
Tel: (519) 888-7070 / Fax: (226) 336-6974
Email: northfield@sosphysiotherapy.ca

○ **SOS ELMIRA**
Behind Wellness Centre (Clock Tower)
3 Wyatt Street East
Suite 2
Elmira, Ontario N3B 2H4
Tel: (519) 669-1212 / Fax: (519) 669-0800
Email: elmira@sosphysiotherapy.ca

Rev. November 2020

Chart # _____

Today's Date: _____

Gender: _____

Preferred Pronouns: _____

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 $70.00 will be charged for any late cancellation or no-show appointment.**

Name: _____
Verify if there is an Apt. or Unit #.

How did you hear about us? _____

AFFIX LABEL HERE

Email Address: _____

Occupation: _____

Emergency Contact:
Name _____
Daytime Phone # _____

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

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: _____

SUBMIT