Total Balance PHYSIOTHERAPY

Bracebridge – 2-36 McDonald Street
P: (705) 646-2299 F: (705) 646-2709
Gravenhurst – 241 Brock Street
P: (705) 640-2299 F: (705) 640-2709

Confidential Patient Information

Date: D/M/Y ______/______/______

Legal Name: Mr/Mrs/Ms ____
Preferred Name (If different)____
Date of Birth: D/M/Y ______/______/______ **Age:** ____________________
Occupation: ____
Marital Status: Single Married Common-Law Separated Divorced Widowed
Home Phone: ____________________ **Alt. Phone:** _____________________
Home Address: ____
______________________________ **Postal Code:** ______________________

Appointment Reminder: All clients will receive a reminder notice of an upcoming appointment on the day before it is scheduled. For your convenience you may select one, or more, ways to receive your reminder.

○ Email: ____

○ Text Message: #_______________ ○ Phone Call: #_______________

Please note that SAME DAY cancellations or no shows will be charged a $25 cancellation fee, due at the next appointment date.

Family Physician: ______________________ **Location:** ___________________
Referring Physician: ____________________ **Location:** ___________________

I grant permission to Total Balance Physiotherapy to share my confidential health information with my family doctor and ONLY AS NECESSARY with third party payers, my employer (if WSIB), and other health professionals.

Signature: ____________________________________

Workplace Injury (WSIB)
Is this a work related injury? No Yes (If yes, continue with this box)
Date of Accident: D/M/Y ______/______/______

Please fill out the **WSIB Intake Form** provided.

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General Health Questionnaire

To ensure the safety of our clients, the following information is required prior to your assessment. If you have any of the following conditions, or have had any in the past, please check yes and give details in the space provided. If you have any questions, please ask.

Medical Condition	No	Yes	Medical Condition	No	Yes
1. High Blood Pressure	□	□	15. Thyroid	□	□
2. Low Blood Pressure	□	□	16. Depression	□	□
3. Heart Condition	□	□	17. Infectious Disease	□	□
4. Circulatory Problems	□	□	18. Haemophilia	□	□
5. Blood Disease	□	□	19. Allergies	□	□
6. Asthma	□	□	20. Pacemaker	□	□
7. Lung Condition	□	□	21. Swelling of legs/feet	□	□
8. Shortness of Breath	□	□	22. Skin Conditions	□	□
9. Epilepsy	□	□	23. Metal Implants	□	□
10. Diabetes	□	□	24. Fibromyalgia	□	□
11. Cancer	□	□	25. Chronic Fatigue Syndrome	□	□
12. Osteoporosis	□	□	26. Environmental Sensitivities	□	□
13. Osteoarthritis	□	□			
14. Rheumatoid Arthritis	□	□			

Details/Other: ____
____

Any previous surgeries?	Yes:____ ____ ____
Please list any current medications?	____ ____ ____
Have you been treated for any other medical condition not listed above?	Yes:____ ____ ____ ____

Do you smoke? No □ Yes □ Packs per day____________ Total years____________

Females: Are you pregnant? No □ Yes □

Are you currently planning to become pregnant? No □ Yes □

Signature: ________________________ **Date**: _____/_____/_____