

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: _____

Email Address: _____

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.

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	<input type="checkbox"/>	<input type="checkbox"/>	15. Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
2. Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	16. Depression	<input type="checkbox"/>	<input type="checkbox"/>
3. Heart Condition	<input type="checkbox"/>	<input type="checkbox"/>	17. Infectious Disease	<input type="checkbox"/>	<input type="checkbox"/>
4. Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	18. Haemophilia	<input type="checkbox"/>	<input type="checkbox"/>
5. Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	19. Allergies	<input type="checkbox"/>	<input type="checkbox"/>
6. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	20. Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
7. Lung Condition	<input type="checkbox"/>	<input type="checkbox"/>	21. Swelling of legs/feet	<input type="checkbox"/>	<input type="checkbox"/>
8. Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	22. Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>
9. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	23. Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
10. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	24. Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
11. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	25. Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
12. Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	26. Environmental Sensitivities	<input type="checkbox"/>	<input type="checkbox"/>
13. Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>			
14. Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>			

Details/Other: _____

<u>Any</u> previous surgeries?	Yes: _____ _____ _____
Please list <u>any</u> 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: ____/____/____