Physiotherapy III LTD.
www.physio3.com

Owen Sound Clinic
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Port Elgin, ON N0H 2C4
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Best of the BEST READERS CHOICE AWARDS '19 SILVER

Information Sheet

Date: _____Name: _____
Address:_____
Postal Code: _____Home Telephone: _____
Work Telephone:_____Date of Birth: _____
E Mail _____

In case of Emergency, please notify:
Name: _____ Telephone: _____
Family Physician:_____ Specialist:_____
Date of Accident: _____

Where did you hear about us? Newspaper☐ Doctor☐ Friends/Relatives☐ Seminars☐ Flyers☐ Other☐

Are you currently seeing any of the following: Chiropractor ☐ Massage Therapist ☐

PLEASE COMPLETE THE APPROPRIATE SECTION:

WSIB
☐ WSIB #_____SIN (WSIB only) _____
Employer: _____Supervisor: _____
Phone:_____Fax:_____

MOTOR VEHICLE ACCIDENT INFORMATION

☐ MVC Insurance Co._____Claim #: _____Policy# _____
Agent: _____Branch Location/Address: _____
Adjuster Phone No. _____Adjuster Fax No._____
If you have Collateral Benefits (ie. Work Benefits) for MVA only, please complete:
Carrier: _____Policy and/or Plan #:_____

Medical History:
Have you ever been told you have:

- Cancer ☐Yes ☐No _____
- Diabetes ☐Yes ☐No _____
- Hypoglycemia ☐Yes ☐No _____

- Hypertension or high blood pressure ☐Yes ☐No _____
- Heart disease ☐Yes ☐No _____
- Angina or chest pain ☐Yes ☐No _____
- Shortness of breath ☐Yes ☐No _____
- Stroke ☐Yes ☐No _____
- Kidney disease/stones ☐Yes ☐No _____
- Urinary tract infection ☐Yes ☐No _____
- Allergies ☐Yes ☐No _____
- Asthma, hay fever ☐Yes ☐No _____
- Cirrhosis/liver disease ☐Yes ☐No _____
- Rheumatic/scarlet fever ☐Yes ☐No _____
- Polio ☐Yes ☐No _____
- Chronic bronchitis ☐Yes ☐No _____
- Pneumonia ☐Yes ☐No _____
- Emphysema ☐Yes ☐No _____
- Migraine headaches ☐Yes ☐No _____
- Anemia ☐Yes ☐No _____
- Ulcers/stomach problems ☐Yes ☐No _____
- Arthritis/gout ☐Yes ☐No _____
- Blood related condition ☐Yes ☐No _____

(i.e. Hemophilia, Hepatitis, Guillan-Barre syndrome)

- Epilepsy ☐Yes ☐No_____
- Thyroid problems ☐Yes ☐No_____
- Multiple sclerosis ☐Yes ☐No _____
- Tuberculosis ☐Yes ☐No _____
- Fibromyalgia/Myofascial Pain Syndrome ☐Yes ☐No_____
- Other (please describe) ☐Yes ☐No _____
- Are you pregnant? ☐Yes ☐No _____
- Is there a chance you maybe pregnant? ☐Yes ☐No _____
- Osteoporosis ☐Yes ☐No _____
- Latex Intolerance ☐Yes ☐No _____

Work Environment

1) Occupation:

_____

2) Does your job involve:

□ prolonged sitting (e.g. desk, computer, driving)
□ prolonged standing (e.g. equipment operator, sales clerk)
□ prolonged walking (e.g. mill worker, delivery service)
□ use of large or small equipment (e.g. telephone, fork lift, keyboard, drill press, cash register)
□ lifting, bending, twisting, climbing, turning
□ exposure to chemicals, pesticides, toxins, or gases
□ other: please describe

_____

3) Do you use any special supports:
□ back cushion, neck cushion
□ back brace, corset
□ other kind of brace or support for any body part

4) History of falls:
□ I have had no falls
□ I have just started to lose my balance/fall
□ I fall occasionally
□ Certain factors make me cautious (e.g. curbs, ice, stairs, getting in and of the tub)

Medical Testing

1) Are you taking any prescription or over-the-counter medications? ☐Yes ☐No
If yes, please list and what they are for:
_____
_____

2) Have you noticed any lumps or thickening of skin or muscle anywhere on your body? ☐Yes ☐No

3) Do you have any sores that have not healed or any changes in size, shape or color of a wart or mole? ☐Yes ☐No

4) Have you had any unexplained weight gain or loss in the last month? ☐Yes ☐No

5) Do you smoke or chew tobacco? ☐Yes ☐No
If yes, how many pack/day? _____
For how many months or years? _____

6) How much alcohol do you drink in the course of a week: _____

7) How much caffeine do you consume daily (including soft drinks, coffee, tea or chocolate)?
_____

8) Are you on any special diet prescribed by a physician? ☐Yes ☐No

9) Do you have a pacemaker, transplanted organ or metal implants/joints replacements? ☐Yes ☐No

Payment for services is due on receipt unless our office has confirmation of other funding sources.

Please let the clinic know at least 24 hours before your appointment if you are unable to attend, or a late cancellation fee will be applied to your account.

I hereby consent to physiotherapy treatment as explained to me.

We may obtain your health information from other healthcare providers to continue to care for you. We may also on occasion share this information with other healthcare providers for the purposes of continuity of care. This includes healthcare providers at other organizations who are able view your information through shared electronic systems/databases.

_____	_____	_____
Print Name	Signature	Date
_____	_____	_____
Witness Name	Signature of Witness	Date