Physiotherapy III LTD
www.physio3.com

Owen Sound Clinic
1156 2nd Ave East
Owen Sound, N4K 2H9
Tel: 519-372-1920
Fax: 519-372-1888
Email: info@physio3.com

Port Elgin Clinic
609 Bricker Street
Port Elgin, ON N0H 2C0
Tel: 519-389-3393
Fax: 519-389-5888

Healing Waters Clinic
R.R.#2, 318383 Grey Road 1
Owen Sound, ON N4K 5N4
Tel: 519-370-2333

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 _____

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- 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 _____

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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

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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