



Owen Sound Clinic

1156 2nd Avenue East
Owen Sound, ON N4K 2H9
T: 519-372-1920 • F: 519-372-1888

Healing Waters Clinic

318383 Grey Road 1
Owen Sound, ON N4K 5N4
T: 519-370-2333

Port Elgin Clinic

553 Bricker Street
Port Elgin, ON N0H 2C4
T: 519-389-3393 • F: 519-389-5888



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
(i.e. Hemophilia, Hepatitis, Guillan-Barre syndrome) | Yes | No | _____ |
| ● 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