Evolution PHYSIOTHERAPY

P4 Instrument

When answering these questions, think only of the pain you are experiencing in relation to the problem for which you are having treatment.

Circle 1 number for each of the 4 questions. On average, how bad has your pain been:

	No Pain										Pain as bad as it can be
In the morning over the past 2 days?	0	1	2	3	4	5	6	7	8	9	10
In the afternoon over the past 2 days?	0	1	2	3	4	5	6	7	8	9	10
In the evening over the past 2 days?	0	1	2	3	4	5	6	7	8	9	10
With activity over the past 2 days?	0	1	2	3	4	5	6	7	8	9	10

MEDICAL HISTORY

Do <u>YOU</u> have a history of: Please check the appropriate response (Yes or No). If yes, please explain below.

	Y	N		Y	N
Osteoarthritis	_____	_____	Diabetes	_____	_____
Rheumatoid Arthritis	_____	_____	Thyroid Problems	_____	_____
Osteoporosis	_____	_____	Glandular Problems	_____	_____
Other Bone or Joint problems	_____	_____	Skin Conditions	_____	_____
Muscular Disorder	_____	_____	Disease of any Internal Organs	_____	_____
Stroke	_____	_____	Cancer	_____	_____
Epilepsy	_____	_____	Communicable Disease	_____	_____
Multiple Sclerosis	_____	_____	Sudden, Unexpected Weight Loss	_____	_____
Other Neurological Disorders	_____	_____	Dizziness	_____	_____
Heart Attack	_____	_____	Fainting	_____	_____
Pacemaker	_____	_____	High Blood Pressure	_____	_____
Angina	_____	_____	Low Blood Pressure	_____	_____
Other Heart Problems	_____	_____	Anticoagulant Therapy	_____	_____
Breathing Disorders	_____	_____	High dose of Steroid Therapy	_____	_____
Incontinence/leaking	_____	_____	Are you currently pregnant?	_____	_____

Explanation: _____

_____

_____

Medications – Please list all current:_____

_____

List Previous Musculoskeletal injuries (low back pain, sprains, strains, etc.), fractures, surgeries and hospitalization:

_____

_____

_____

Name (print): _____ Signature:_____ Date: _____

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PHYSIOTHERAPY

Client Information

Name: _____ Date of Birth: _____

Address: _____ Phone (H): _____

City and Province: _____ Phone (W): _____

Postal Code: _____ Phone (C): _____

Email: _____

Emergency Contact – Name: _____ Phone: _____ Relation:_____

Reason for booking appointment: _____ _____

If your injury is the result of a Motor Vehicle Accident, please inform the front desk before continuing with this form

Do you belong to a gym facility: ☐ Yes ☐ No If yes, please specify: _____

Do you have a family physician? ☐ Yes ☐ No If yes, whom: _____

How did you hear about us?

☐ Referred by a physician: _____

☐ Referred by another patient: _____

☐ Other (please specify): _____

Health Insurance and Cancellation Policy

Services provided by Evolution Physiotherapy are not covered by OHIP; therefore, you are responsible for full payment of your account. We are, however, able to submit electronically on your behalf to many insurers.

If you want us to submit electronically on your behalf:

Provider: _____ Policy #: _____ Member ID: _____

For coverage of spouse or child, provide Member's full name_____

Cancellation Policy: A minimum of 24 hours notice is required to cancel a scheduled appointment. You agree to pay the full service fee for any missed or late-cancelled appointments. Your therapist does not get paid if you do not show up for your appointment or give enough notice to book another client. Please arrive on time. If you are late, you are taking away from your own assessment/treatment time.

☐ I fully understand the clinic policy and agree to abide by it.

Signature:_____ Date:_____

Consent to the Collection, Use and Disclosure of Personal Health Information

Note to client: We want your informed consent. We want you to understand what we do with the personal health information we collect about you. Please ensure that you have read and understood our written statement, "Our Privacy Commitment to You". If you have any questions, please ask.

I, _____, understand that to assess my health concerns and provide physiotherapy services, Evolution Physiotherapy will collect personal information about me.

I have reviewed Evolution Physiotherapy's written statement on the collection, use and disclosure of personal health information, and understand how that statement applies to me. I have been given a chance to ask questions about Evolution Physiotherapy's privacy policies and they have been answered to my satisfaction.

I understand that Evolution Physiotherapy will only collect, use or disclose my personal health information with my express or implied consent, unless a collection, use or disclosure without consent is permitted or required by law.

I authorize Evolution Physiotherapy to collect, use and disclose my personal health information for the following purposes (indicate your consent by checking the applicable boxes):

- ☐ To assess my health care concerns, advise me of my treatment options, and provide physiotherapy treatment.
- ☐ To send me appointment reminders, home exercises, and correspondence from my physiotherapist.
- ☐ To communicate with other health care providers involved in my treatment.
- ☐ To allow Evolution Physiotherapy to follow-up with me regarding assessment, treatment and billing.
- ☐ To complete or verify claims for insurance purposes.
- ☐ To send me news and information about Evolution Physiotherapy, including new services, events and programs.

I understand that I can withdraw my consent at any time by contacting either Allen Hicks, the Health Information Custodian, or Rhonda MacLean, the Information Officer.

I hereby agree to Evolution Physiotherapy collecting, using and disclosing my personal health information as set out above and in the written statement “Our Privacy Commitment to You”.

_____ _____

Patient's Signature *(or parent/guardian, if patient* is *under 16)* Printed Name

_____

Date

Revised: Sept. 27, 2016

Payment options are:

☐ 1. Pay at each appointment

- Pay at each appointment using any accepted payment method (cash, cheque, interac, Visa, Mastercard)

☐ 2. Credit card number and expiration date kept on file

- Outstanding accounts will be automatically billed to your credit card
- Option to pay at each appointment or weekly

☐ I authorize Evolution Physiotherapy to bill any outstanding account balance to my credit card:

- ☐ At each appointment
- ☐ At end of week

Visa No. _____ Expiration Date _____

Mastercard No. _____ Expiration Date _____

Name (print clearly) _____

Cardholder Signature _____

Date _____

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Dry Needling Consent Form

Dry Needling is a treatment used to help relax tight bands of muscle that result from altered nerve functioning. This treatment uses very fine acupuncture needles to release these abnormal bands in the muscle. No drugs are administered, and it is particularly helpful for those patients who suffer from chronic soft tissue pain or degenerative changes of the spine.

Like any form of medical treatment, there are possible complications. While these are extremely rare, they must be considered prior to giving your consent to the procedure.

Anytime there is a needle used there is a risk of infection. In our clinic the therapist uses disposable, sterile needles; swabs the skin with an antibacterial solution; and uses medical gloves for the procedure.

A needle may be placed inadvertently into an artery, nerve, or vein. If an artery or vein is punctured, a bruise may develop. If a nerve is punctured you may experience a prickling sensation for a few days.

When a needle is placed close to the chest wall, there is a rare possibility of puncturing the lung. This complication is not fatal and can be readily reversed, but does require medical attention. Should you ever leave the physiotherapy clinic and notice obvious shortness of breath, that is not normal for you, you should take yourself to the hospital and tell them you have been needled.

Dry Needling may cause an increase in pain for 1 or 2 days which is usually followed by an improvement in the overall pain state.

It is also very important that you inform your therapist of the following conditions:

Pregnancy	yes	no	Pace Makers	yes	no
Joint Replacements	yes	no	Bleeding Disorders	yes	no
Blood Thinners	yes	no	Antibiotics	yes	no
HIV	yes	no	Blood Transfusions	yes	no
Hepatitis	yes	no	Immunosuppression Drugs	yes	no
Surgeries	yes	no	What/When _____		
			_____		

I consent to be treated with Dry Needling

Signed: _____ Printed Name: _____

Date: _____