ARK Physiotherapy & Pain Relief

7c-1201 Britannia Road west, Mississauga, ON L5V 1N2

General Information: ☐ Extended Health Benefit: _____

Last Name: _____ First Name: _____

Gender: ☐ Male ☐ Female Date of Birth: (DD/MM/YYYY) _____

Address: _____ Home Phone: _____

_____ Cell/Work Phone: _____

Email: _____ ☐ I wish to receive my appointments by Email

Whom we can thank for referring you: _____ / Walk-in / Internet

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Is this is an injury due to a Car accident: ☐ YES ☐ NO Claim #_____

IS this is a work related injury (WSIB): ☐ YES ☐ NO Claim #_____

Main Complaints _____

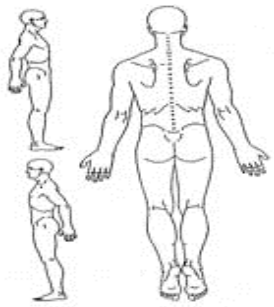
Onset & Cause: _____

Describe Your Pain: (Dull/Sharp etc.) _____

Rate your pain: (None) 1 2 3 4 5 6 7 8 9 10 (Unbearable); Constant or Intermittent

What makes your pain worse? _____

What relieves your pain? _____



Please mark the painful areas

Missed Appointment(s) Policy:

At least 24 hours notice is required for any cancellation or rescheduling for your appointment. Failure to do so will result in a full service fee charge. (Except during emergencies)

Declaration & Consent:

I hear by authorize *ARK Physiotherapy & Pain Relief* to furnish to my insurance company, their employees & agents, physician, employer, lawyer or WSIB any relevant information directly related to my health condition and treatment at this clinic.

As a part of the treatment such as physiotherapy / chiropractic / massage treatments, some procedure and equipment may be used such as the use of hot pack, ice, electrotherapy, ultrasound, acupuncture and hands-on manual therapy. I understand that Physiotherapy assistant or aide will be part of the team providing my treatment. I will have the opportunity to discuss with the chiropractor/physiotherapist and/or other clinical staff, the nature and purpose of treatments. I understand the results are not guaranteed.

I further understand and I am informed that there are some very minor risks to treatments, including, but not limited to, muscle strains, sprains, disc injuries, and burns have been made aware that there are rare chances of injury and that suitable tests will be performed to help identify if I may be susceptible to risk or injury.

I have read and understood the above statement, accept the risk and hereby consent to treatment. I am fully responsible for informing *ARK Physiotherapy & Pain Relief* of any changes to above information and my health status.

I have also been informed about the fees and am responsible for the payment of all charges related to my visit at ARK Physiotherapy & Pain Relief.

Patient Signature: _____ Date: (DD/MM/YYYY) _____

Parent/Guardian Signature: _____ Date: (DD/MM/YYYY) _____
(If patient is less than 16 years of age)

Witness Signature: _____ Date: (DD/MM/YYYY) _____

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The health information collected issued to ensure the highest quality of care, and will remain confidential as part of your file. If you answer yes to any of the following, please give more details in the space provided below.

Patient's Name: _____ DATE OF BIRTH: _____

Please mark all that is applicable:

- ☐ Heart problems
- ☐ Pacemaker
- ☐ Stroke
- ☐ Low/high blood pressure
- ☐ Epilepsy/seizures
- ☐ metal implants
- ☐ Diabetes
- ☐ Depression
- ☐ Sleep Disturbances
- ☐ Pregnant
- ☐ Allergies :_____
- ☐ Repeated infections/ HIV / AIDS
- ☐ Cancer
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Thyroid condition
- ☐ Cholesterol
- ☐ Skin disease or sensitivity
- ☐ Asthma
- ☐ Lung Problems
- ☐ Leg Swelling

List any major surgeries or conditions not listed above:

_____

_____

_____

List any medications you are currently taking and for what conditions:

_____ _____

_____ _____

My **GOAL** from the treatment Program at this clinic is to:

_____

I am **HOPEFUL** that I will be successful at achieving my above goal: (Circle that apply)

1	2	3	4	5
Strongly disagree	Disagree	Neither agree or disagree	Agree	Strongly agree

Signature: _____ **Date:** (DD/MM/YYYY) _____