Ottawa Integrative Health Centre Inc.
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Physiotherapy Intake

Patient Information

Name_____

Date_____

Address_____

City_____ Province_____ Postal Code_____

Home Phone_____
Cell Phone_____
Work Phone_____

E-Mail_____

□ Yes, sign me up for the monthly e-newsletter

Date of Birth *day* _____ *month* _____ *year* _____ Age_____

Occupation_____

Referred By_____

Emergency Contact Information

Name_____Relation_____

Phone_____ E-mail_____

Other Health Care Providers

1._____

2._____

3._____

Health Information:

Are you currently taking any prescription or over the counter medication (please list):

_____

_____

Please list any surgeries and approximate dates:

_____

_____

Have you ever been diagnosed with the following (please provide details)

Cancer	Y	N	_____
Diabetes	Y	N	_____
Heart Disease	Y	N	_____
Neurological Disease	Y	N	_____
Thyroid Dysfunction	Y	N	_____
High Blood Pressure	Y	N	_____
Fibromyalgia	Y	N	_____
Kidney Disease/Stones	Y	N	_____
Colon Disease	Y	N	_____
Osteoporosis/Osteopenia	Y	N	_____
Arthritis	Y	N	_____
Allergies	Y	N	_____
Asthma	Y	N	_____
Immune Disorder	Y	N	_____
Anemia	Y	N	_____
Other			_____

In the past 6 months have you experiences any of the following?

Migraines/Headaches	Y	N	_____
Shortness of Breath	Y	N	_____
Vision/Hearing Disturbances	Y	N	_____
Fainting	Y	N	_____
Nausea/Vomiting	Y	N	_____
Sleep Disorder	Y	N	_____
Unexplained Weight Loss	Y	N	_____
Incontinence of Bowel/Bladders	Y	N	_____
Heaviness in the Pelvis	Y	N	_____
Pain with intercourse	Y	N	_____

For Women:

Are you currently pregnant/do you suspect that you are pregnant? _____

Number of Pregnancies_____ Number of Births_____

Patient/Client Agreement Form
Each patient/client is required to read the following before treatment.
Your signature below acknowledges the following:

1. I understand that Physiotherapy and other services provided at OIHC are not covered by the provincial government, yet their expenses may be covered by private insurance plans and may be tax deductible.

2. The fees and services have been clarified in advance. Payment is due at the end of each visit as the clinic does not bill insurance companies directly. Cash, cheque, Interac, Visa, and MasterCard (no other credit card) are acceptable methods of payment

3. Forty-eight hours notice is required when cancelling or changing an appointment. Otherwise, I understand that I will be charged for 50% of the missed appointment.

4. Items purchased are non-refundable, whether or not they have been opened.

5. I understand that physiotherapy is a joint responsibility between me (the patient/client) and my practitioner.

6. I understand that I may contact my health care provider by phone or e-mail and that all emails will be screened by reception and forwarded to the appropriate Physiotherapist

7. I realize that integrative health care/medicine is not an isolated system and that all our health care providers welcome teamwork with NDs, MDs, DCs, RMTs, and other health practitioners.

Patient Signature_____

Date_____