HALTON Chiropractic AND WELLNESS CLINIC

250 Wyecroft Road, Suite #5
Oakville, ON L6K 3T7
Tel: 905.844.9117
Fax: 905.844.9118
www.haltonchiropractic.ca

PHYSIOTHERAPY

NEW PATIENT QUESTIONNAIRE

Name: _____ Date: _____
(Last) (First)

Address: _____
(Street) (City)

_____
(Province) (Postal Code)

Phone: Home (____)_____ Work (____)_____ Cell (____)_____

E-mail Address: _____

Date of birth: _____ Age: _____ Height: _____
(Day / Month / Year)

Birth Place: _____ Weight: _____

Gender: M or F (Please Circle) # of children: _____

Emergency Contact: _____ _____ (___)_____
(Name) (Relationship) (Phone)

Family physician: _____ Referred by: _____

Occupation: _____

Employer's Name: _____

Employer's Address: _____

What brings you in for physiotherapy? _____

Have you had any previous treatment for this condition? If so when? _____

! **<u>Please note:</u>** Your appointment time is your treatment time. **Please cancel appointments no less than 24 hours prior or a full fee will be charged.** The same applies for missed appointments.

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INFORMED CONSENT: PHYSIOTHERAPY

Helena Greyvenstein, B.Sc., P.T. is a registered physiotherapist. Physical Therapy is a health care profession directed at evaluating, restoring and maintaining physical function through the use of physical agents such as sound, electrical energy and exercise. I understand that my physiotherapist may introduce acupuncture as a treatment technique in my care and that if I consent to this form of treatment I will do so willingly and only if informed of the benefits and risks of such treatment.

I agree to undergo a physical therapy assessment and will then discuss my treatment options directly with my physiotherapist prior to initiation of a treatment program. I will discuss any concerns I have regarding proposed treatments and will be able to withdraw consent at any time.

I understand that this consent to assessment and treatment pertains only to physical therapy services provided by Helena Greyvenstein, B.Sc., P.T.. I understand that my physiotherapist will be the health information custodian for my clinical record, and that it will only be shared among practitioners with my express consent and for use in my concurrent care with other clinic practitioners.

Privacy Policy: Please review the attached **Privacy Policy Overview.** This policy has been written with the guidelines set out by the Privacy Commissioner of Canada. (Personal Information Protection and Electronic Documents Act).

_____	_____
Patient name (print)	Signature of Patient or Legal Guardian
_____	_____
Therapist Signature	Date