History Intake Form

Name ___________________________ **Birth date** _____________________
(month/day/year)
Address__________________________
Postal Code ______________________ **Family Doctor** _________________
Phone(home)______________________ Phone ________________________
(cell) _______________________ **Referring Professional:**
(work)______________________ ______________________________
Email____________________________ Phone_________________________
Occupation _______________________ **PHN**? _________________________
ICBC or **WCB**? Claim # _____________

Please indicate if you believe any of the following apply to you: **(P= past C=current)**

___ Heart Attack
___ High/Low Blood Pressure
___ Stroke/ Aneurysm
___ Other Heart Conditions
___ Varicose Veins
___ Bruise easily
___ Other Circ. Conditions
___ Diabetes
___ Kidney Disease
___ Other Urinary Condition
___ Pregnant
Due Date: __________

___ Headaches/ Migraines
___ Dizziness/ Fainting
___ Nausea
___ Spinal Injury
___ Head Injury
___ Epilepsy/Seizures
___ Neurological condition
___ Asthma
___ Chronic Sinusitis
___ Respiratory Condition
___ Irritable Bowel/Colitis
___ Digestive Condition
___ Skin Condition

___ Joint Dislocation
___ Bone Fracture
___ Arthritis
___ Osteoporosis
___ Rods/Pins/Plates
___ Implants __________
___ Transplant
___ Corrective Lenses
___ Cancer
___ Hepatitis
___ HIV
___ Contagious Condition:
____

Please list any medications you presently take:
____

Known Allergies (including medications, foods, seasonal, oils, lotions, etc.):
____

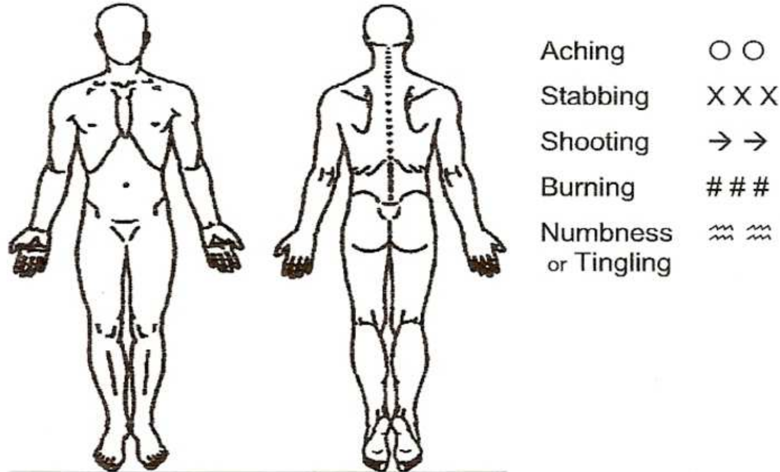
Have you ever been hospitalized, had any major accidents, illnesses or surgeries?
Please comment:____

Other therapy/ treatment: (Chiropractor, Physiotherapy, Naturopath, Acupuncture, etc.)
____

List any activities, sports, hobbies:
____

Current Condition

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:



Please describe your current condition & symptoms:
____
____
____

How long have you had this condition?
____How did it start?
____

what aggravates it? ____
what relieves it? ____

____

Payment for all treatments, whether private or insured, is ultimately the responsibility of the patient.

I authorize Seva Physiotherapy to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition I authorize Seva Physiotherapy to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature: __________________________

Date: ______________________________

OFFICE POLICY

Appointments:
- ✓ Please be on time, sign in for each of your appointments and bring your appointment card
- ✓ Book your appointments at the beginning of each week for the next week
- ✓ Cancel your appointment if you are unable to attend, if you miss several appointments without reason, we may have to notify your physician or insurance company and you may be discharged
- ✓ Patients will be charged $25.00 for all missed appointments.

Clothing and attire:
- ✓ Wear appropriate footwear. Runners only. No work boots, open toe shoes, slip on's or heels.
- ✓ Wear appropriate workout attire (t-shirt, sweatshirt , sweatpants , shorts).
- ✓ No perfumes, strong body odors, or excessive scents
- ✓ It is appreciated if all patient's wear clean clothes & have proper hygiene.

Safety:
- ✓ Children must be under adult supervision and are not to play with any equipment
- ✓ Please notify your treating therapist of any change in your condition or anything you are unsure about
- ✓ Please call for assistance immediately if you are in any discomfort during your treatment
- ✓ If you have inhalers or nitro spray, please have it with you at all times while in the clinic

Food and Drinks:
- ✓ No food or drinks are allowed beyond the waiting room area.

Lost or Stolen Items:
- ✓ We are not responsible for any items lost or stolen while attending our facility.
- ✓ Please do not bring or wear expensive or irreplaceable items with you to your treatment sessions, they may have to be removed in order for you to receive treatment.

Reports/ Work Notes:
- ✓ A fee will be charged for reports and / or work notes
- ✓ Please see our receptionist for further details.

Worker's Compensation Claims (WorksafeBC) / Work Injuries:
- ✓ If you are attending treatment as a result of a work injury, you must report your injury to the appropriate agencies.
- ✓ You are also responsible for providing our office with your claim number as soon as it is issued.
- ✓ Our office staff would be happy to assist you with this in any way possible.
- ✓ Please be aware that if your claim through WorksafeBC is denied, you are responsible for any and all charges accrued for your treatment at our facility.

Private Insurance Coverage:
- ✓ Most extended health benefits cover physiotherapy and massage therapy.
- ✓ Please contact your policy administrator for details for reimbursement
- ✓ You are responsible for paying at the time of visit

Motor Vehicle Accident Injuries (ICBC):
- ✓ If you are attending treatment as a result of a motor vehicle accident, you must provide our office with all the relevant information (claim number, adjustor name, etc.) for us to process your claim.
- ✓ Our office staff would be happy to assist you with this in any way possible.
- ✓ Please be aware that if your claim through ICBC is denied, you are responsible for any and all charges accrued for your treatment at our facility.

____________________________ ____________________________

Patient Signature Date