PRO MOTION PHYSIOTHERAPY

PATIENT INFORMATION SHEET

DATE: _____

NAME: _____ DATE OF BIRTH: ____/___/___ GENDER: □M □F
(Last) (First) YYYY MM DD

ADDRESS: _____ _____ _____ _____ _____
(Number) (Street) (City) (Province) (Postal Code)

CELL PHONE: _____ HOME PHONE: _____ WORK PHONE: _____

E-MAIL ADDRESS: _____
(Permission to contact by e-mail: □Yes □No)
Best method to be contacted: □ Cell □ Home □ Work □ E-mail

Specialist: _____ _____ Family Doctor: _____ _____
(Name) (Initial) (Phone No.) (Name) (Initial) (Phone No.)

Permission to send report to: Specialist □ Yes □ No Family Doctor □ Yes □ No

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How did you hear about Pro Motion Physiotherapy?
□ Doctor _____
Name
□ Internet □ Our Web Page □ Canada 411 □ Yellow Pages Phonebook □ Phone App
□ Ontario Physiotherapy Association – Find a Physio □ College of Physiotherapists – Find a Physiotherapist
□ Arthritis Society □ Robin McKenzie Institute
□ Promenade Mall Advertising
□ Someone who has been here before _____ May we send them a thank you note? □ Yes □ No
Name
□ I had treatment at Pro Motion Physiotherapy in the past
□ Other _____

Would you like to receive information about upcoming lectures, special events, clinic news, and health and wellness?
□ Yes □ No

Consent for Assessment:
I understand that a Registered Physiotherapist will be performing my assessment and will discuss treatment with me. The fee for the first visit is _____.

Please see our website for our privacy policy.

_____
Signature

(Nov 2016)

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O'Hare Physiotherapy Professional Corporation

Pro Motion Physiotherapy Health Questionnaire

Patient Name: _____ **Date:** ___ / ___ / ___

Please complete this form to ensure optimum care. Information will remain confidential and be a part of your physiotherapy chart. Please notify us of any change in your medical status. If you would like to see our privacy policy, please let us know. Check the box if you have any of the following:

Heart disease	☐	High Blood Pressure	☐
Pacemaker	☐	Breathing problems	☐
Diabetes	☐	Epilepsy	☐
Bleeding disorder	☐	Major surgeries	☐
Cancer	☐	Neurological disorder	☐
Osteoporosis (Osteopenia)	☐	Allergies	☐

Please provide details to any you have marked:

_____

_____

1. Are you pregnant? Yes No
2. Do you smoke? Yes No
3. Please list any medications you take:

_____

_____

4. Please list any x-rays, scans or investigations you have had in the past year_____
5. Do you have any metal in your body e.g. Joint replacement, pins, plates, screws, stents

_____

6. Are you presently receiving any other therapy e.g. massage, chiropractic, physiotherapy

_____

7. Is there anything else about your health we should be aware of? Yes No
   Please explain: _____

   _____

Please complete : Circle **Yes** or **No**

1.	I am currently physically active	**Yes**	**No**
2.	I intend to become more physically active in the next 6 months.	**Yes**	**No**
3.	I currently engage in **regular** physical activity i.e.30 minutes or more at least 5 days a week	**Yes**	**No**
4.	I have been **regularly** physically active for the past six months	**Yes**	**No**

EMERGENCY CONTACT: Name: _____ **Phone: ( )**

Relationship to you: _____