PATIENT INFORMATION

Name: **Home #:** - - **Cell #:** - -

Address: **City:** **Postal Code:** -

E-mail: **Occupation:**

Date of Birth (dd/mm/yyyy):

Family/Referring Dr.:

Emergency Contact Name: **#:** - -

PAYMENT POLICY

FEES:

Initial Assessment/Consultation	**$110.00**
Subsequent Treatments	**$70.00**
Shockwave Treatments	**$100.00**

If the services provided are not covered by my insurance, employer or other third party, I understand that I am responsible for paying any outstanding balance including deductibles.

If you would like FreeFlo Physiotherapy to direct bill your insurance company, I understand that my credit card will be kept on file to cover any outstanding balances. You will be notified prior to any charges to the credit card.

Credit Card Type/Number:_____ Exp:_____ CVC: _____

FreeFlo respectfully requires patients to provide 24 hours notice for appointment cancellations. Consequently, I acknowledge that if I do not provide 24 hours notice, I may be charged a cancellation fee (not payable by insurance).

Signature: _____

COMMUNICATION AND CONSENT TO RELEASE INFORMATION

I, _____ authorize FreeFlo Physiotherapy to release/obtain information from the following, regarding my care by phone, fax, email, report, letter or direct communication.

Physician(s)☐ **Insurer**☐ **Employer**☐ **Diagnostic imaging**☐

Signature: _____

HEALTH HISTORY

PLEASE LIST THE FOLLOWING:

1.CURRENT MEDICATIONS/CONDITIONS TREATED PERTAINING TO CURRENT INJURY:

_____

2. INJURIES/SURGERIES, INTERNAL PINS, WIRES, ARTIFICIAL JOINTS: DATE, NATURE,

LOCATION:_____

Please circle any of the following that pertain to you:

RESPIRATORY/CARDIOVASCULAR

- Stroke/CVA
- Low/High Blood Pressure
- Heart Disease/Attack
- Chronic Congestive Heart Failure
- Varicose Veins/Phlebitis
- **PACEMAKER**/Similar Device
- Bronchitis
- Shortness of Breath
- Asthma
- Emphysema

INFECTIONS

- Hepatitis
- Skin Conditions
- TB
- HIV
- Herpes

HEAD/NECK

- History of Headaches/Migraines
- Vision Problems/Loss
- Ear Problems/Loss

WOMEN

- Pregnant, due:_____
- Gynaecological conditions, what?_____
- Overall how is your general health?_____

OTHER CONDITIONS

- Loss of Sensation, where?_____
- Diabetes, Onset_____
- Allergies/Hypersensitivity to what?_____
- Epilepsy
- Cancer, where?_____
- Arthritis

Do you have any other medical/health conditions? (e.g haemophilia, osteoporosis, mental illness, digestive conditions)_____
_____

If applicable, what is the reason you are seeking massage/physiotherapy? Please include the location of any tissue or joint discomfort._____

Client Signature:_____

Date:_____

Initial Health History_____	Update 4_____
Update 1_____	Update 5_____
Update 2_____	Update 6_____
Update 3_____	Update 7_____

The information requested above will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information. FreeFlo Physiotherapy will be the Health Information Custodian for all health information obtained.