Georgian Sports Medicine and Physiotherapy
Patient Intake Form

Patient Demographics

First Name: _____ Last Name: _____

Address: _____

Date of Birth: _____ Health Card Number: _____

Primary Phone #: _____ Secondary Phone #: _____

Email Address: _____

*We will be contacting you via email for appointment reminders

General Information

Referral Source: _____

Occupation: _____

Employer: _____

Medical Information

Family Physician: _____

Specialist(s): _____

Pharmacy Name: _____ Pharmacy Location: _____

Current Medications: _____

_____

_____

Condition(s) for which medications are taken for: _____

_____

Previous medical interventions (surgeries, chemotherapy, radiation, injections, physiotherapy, chiropractic): _____

ALLERGIES: _____

_____

PREGNANT (if yes due date): _____

Do you have extended health insurance? YES ☐ NO ☐

*If "Yes," and you are here for "Physiotherapy" please provide your insurance card to the front if you would like us to submit for you. We do encourage self-submission as reimbursement can be more timely. We do take full payment and will submit on your behalf if desired. Please allow 72 hours for direct deposit reimbursement, or 3-5 days for mailed cheques.

Georgian Sports Medicine and Physiotherapy
Assessment Form

Reason_____

Is this a sport related injury: YES ☐ NO ☐

If YES what sport do you play? _____ Name of Team: _____

How long have you had this condition? _____

Have you had this condition before? _____

Was this condition treated? YES☐ NO ☐

If YES, what treatment did you receive? _____

Was this a sudden onset condition? _____

Where do you feel it the most? _____

Describe your discomfort: _____

What makes this condition worse? _____

What makes this condition better? _____

Does this pain wake you during the night? _____

Have you had any imaging regarding this condition? (i.e. x-ray, ultrasound, MRI, CT Scan)

_____

Where? _____

_____

When? (Approximate) _____

_____

_____

Do you have an upcoming competition(s)/season? _____

Pain Scale: (CIRCLE ONE) with 0/10 being NO PAIN and 10/10 being the worst pain imaginable).

At its WORST: MIN 0 1 2 3 4 5 6 7 8 9 10 MAX

TODAY: 0 1 2 3 4 5 6 7 8 9 10 MAX

I hereby agree that all of the information provided above is correct.

Signature: _____

Georgian Sports Medicine & Physiotherapy
371 Yonge Street, Midland, ON
705.245.3330
sportmedmidland@gmail.com

Georgian Sports Medicine and Physiotherapy
Patient Health History Form

General Symptoms
- ☐ Fainting/Dizziness
- ☐ Difficulty Sleeping/Fatigue
- ☐ Stress
- ☐ Headaches/Migraines
- ☐ Nervousness
- ☐ Numbness/Tingling; Where?
- ☐ Paralysis

Respiratory
- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ Family History of_____

Joint/Muscle Discomfort
- ☐ Jaw
- ☐ Neck
- ☐ Shoulders
- ☐ Arms
- ☐ Hands
- ☐ Upper Back
- ☐ Mid Back
- ☐ Low Back
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ Bursitis
- ☐ Arthritis
- ☐ Family History of Arthritis

Infections
- ☐ Hepatitis
- ☐ Tuberculous
- ☐ HIV/AIDS
- ☐ Herpes
- ☐ Athlete's Foot
- ☐ Warts

Do you have/had?
- ☐ Diabetes Onset
- ☐ Cancer; Where?
- ☐ Epilepsy
- ☐ Aneurysm/Stroke
- ☐ Neuromuscular Conditions
- ☐ Hypo/Hyper Glycaemic
- ☐ Depression
- ☐ Multiple Sclerosis
- ☐ Thyroid Problem
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Mental Illness
- ☐ Artificial Implants/Pins/Plates; Where? _____

Cardiovascular
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Attach/Disease
- ☐ Congestive Heart Failure
- ☐ Stroke/Aneurysm
- ☐ Heart Murmur
- ☐ Pacemaker
- ☐ High Cholesterol
- ☐ Ankle Swelling
- ☐ Cold Hands/Feet
- ☐ Poor Circulation
- ☐ Feet
- ☐ Varicose Veins/Phlebitis
- ☐ Family History of _____

Gastrointestinal
- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Gas/Bloating
- ☐ Colitis
- ☐ Crohn's
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea/Vomiting
- ☐ Ulcer
- ☐ Abdominal Cramps
- ☐ Gallbladder Problems
- ☐ Liver Problems

EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Difficulty Hearing
- ☐ Hearing Aid
- ☐ Stuffed Nose/Sinus
- ☐ Allergies/Hypersensitivity to _____
- ☐ Type of Reaction
- ☐ Swollen Glands

Infections
- ☐ Hepatitis
- ☐ Tuberculous
- ☐ HIV/AIDS
- ☐ Herpes
- ☐ Athlete's Foot
- ☐ Warts

Skin
- ☐ Rashes
- ☐ Excessive Dryness
- ☐ Acne
- ☐ Psoriasis
- ☐ Eczema
- ☐ Skin Cancer
- ☐ Bruise Easily

Georgian Sports Medicine and Physiotherapy
Consent to Obtain & Release

We require your informed consent. This entails your understanding of the services we provide, the costs involved and how your personal information is protected. If you have any questions regarding any of these issues please inquire.

CONSENT TO OBTAIN
I authorize Georgian Sports Medicine and Physiotherapy or its representatives to obtain information and documentation relevant to my assessment and treatment. Further a photocopy of this signed for is sufficient authority to release this information.

CONSENT TO RELEASE
I authorize Georgian Sports Medicine and Physiotherapy or representatives to release information and documentation relevant to my assessment and treatment. Further a photocopy of this signed form is sufficient to release this information.
(If you would like to specify places of information to be obtained and/or released please indicate otherwise this form will be used to obtain information from family medical practices, specialists, hospitals and private clinics offering information relevant to your current injury/medical diagnoses.

Specified places only:

1) _____

2)_____

3) _____

CONSENT FOR THE COST OF OUR SERVICES
I am responsible for any outstanding balance on my account. Payment is due at the time of the service. We accepts Visa, Mastercard, Debit and Cash.

CONSENT FOR PERSONAL INFORMATION
I understand that to provide me with medical interventions, physiotherapy, acupuncture provided by the qualified physiotherapist, chiropractic or massage treatments that Georgian Sports Medicine and Physiotherapy will collect relevant information about me (i.e. Address, Telephone Number, Date of Birth, Doctor's Name and Health History)

I agree to Georgian Sports Medicine and Physiotherapy collecting, using and disclosing personal information about me as set out in this agreement. If chosen to list places to obtain or release information that we may only obtain or release from your specified places. If not we will obtain or release to any medical practitioner/places regarding your current/relevant condition.

Date: _____

Signature: _____ Printed Name: _____

Health Card Number: _____

Address: _____

Witness Signature: _____

Georgian Sports Medicine and Physiotherapy
Payment & Cancellation Policy

PAYMENT POLICY
We require payment for each treatment when the service has been provided. Should you have an extended healthcare plan, you will be given an invoice receipt that will be required to receive reimbursement from your insurance policy.

CANCELLATION POLICY
When you book an appointment with your therapist, this time is reserved for you. Our clinic requires a 24-hour cancellation notice before your appointment time to allow enough time to fill this appointment time with other waiting clients. Please if you have a medical emergency or are sick and it is less than 24 hours let us know anyway as we will try to fill this spot with patients on the wait list. Failure to notify us will result in a cancellation fee charged directly to you and this fee cannot be billed to any insurance company or OHIP.

Cancellation fees are equal to HALF the cost of your service fee. If this cancellation/no show is with Dr. Jones you will be charged a **$50.00** rebooking fee.

I have read and understand the above-mentioned policies and agree to their terms and conditions:

Signature: _____

Date: _____

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