Welcome to the King City Natural Health Centre

We welcome you and look forward to the opportunity of serving your health
needs. Please read the following so you understand our clinic procedures and
policies.

1. Please fill out any intake/health history forms as completely as possible.

2. The majority of our patients will complete an on-line health assessment for a complete health/medical history. Separate instructions will be provided for this assessment.

3. Please arrive on time, or before your scheduled appointments. If there are any special instructions, or specific need for you to arrive ahead of time, our staff will inform you.

4. Appointment changes should be made 24 hours/one business day in advance. This allows us time to schedule someone else in need. We reserve the right to charge a missed appointment fee, equal to the amount of the missed appointment or service.

5. Fees for services, assessments and items dispensed are due in full at the time of service. Payments can be made by cash, personal cheque, VISA, MasterCard and debit.

6. If your insurance company covers the service provided, fees are to be paid at the time of service and we will provide the necessary statements. We will also fill out any insurance forms for you to submit to be reimbursed.

7. Phone consultations in lieu of appointments will be charged at the appointment rate.

8. It through the course of your care, you feel that your needs have not been heard or handled with consideration and efficiency, or you feel there are other ways we can enhance your care, we encourage and

welcome your constructive feedback.

Thank you for choosing our clinic as part of your health team.

I have read and understand the information and policies stated above.

Signed ______________________________ Date ___________________

KING CITY
Natural Health
CENTRE

Physiotherapy Intake Form

It is our pleasure to welcome you to the King City Natural Health Center. To help
us serve you better, please complete the following information. We look forward to working with you to build better health for you and your family.

Name: _________________________________
Birth date: ___________________ **Occupation:** _____________________
Address (street, city, postal code): ____
Email: _________________________________
Home phone: ___________________ **Work phone:** ____________________
Cell: __________________________

Emergency contact name: __________________ **Phone number:** ___________

Family Physician: ___________________

Whom may we thank for referring you?

What is your main reason for seeking physiotherapy?

Has this problem occurred before? Y or N If so, when?

Have you received any other forms of treatment for this condition?

Did your injury occur at work?

Is your injury due to a motor vehicle accident?

Does this problem interfere with: (please circle):
Sleep Daily activities Exercise Walking Sitting Lifting

Is your pain constant or intermittent?

Rank your pain on a scale of 0-10 (0 being no pain and 10 being unbearable pain):

What makes your pain/problem worse?

Does anything make it feel better?

Please list any current medications:

Do you or have you ever suffered from: (Circle or check all that apply)

High/Low Blood Pressure
Stroke
Heart Condition
Pacemaker
Haemophilia
Circulatory Disorders
Tuberculosis
Diabetes
Thyroid Disorder
Cancer
Epilepsy
Peripheral Vascular Disease
Migraines
Asthma
Depression/Anxiety
Osteoporosis/Osteopenia
Fracture/Broken Bones

Do you have any other health issues?

Have you had any surgeries? (List all with dates)

Please list any allergies:

Do you smoke?

Are you pregnant or is there a chance you could be pregnant? (Please let your practitioner know if at any time you think you may be).

Do you participate in exercise? **How often?**

Please list activities:

Do you have any children and if so how many?

What is your occupational stress? (1-10 with 10 being most stressful):

I understand that my personal information will be kept confidential in accordance with The Registered Health Practitioners' Act and Privacy Legislation. I understand and consent to physiotherapy examination and treatment.

Name: ___________________________________

Signed: _________________________________

Date: ____________________