Freedom of Information and Protection of Privacy Act Information (FOIPOP)

All personal information collected is used for internal administrative and medical purposes only. Your clinical records will not be released to any party without a signed release form. If you have any questions or concerns about the clinic privacy policies, please contact the clinic manager (250-642-4911, sookephysio@shaw.ca) for further information.

If you send your receipts to an insurance company for reimbursement, they sometimes require additional clarifying information about the dates of your treatments. Without your permission, we are not allowed to provide that information, so your receipts will be sent back to you.
Do you wish for us to provide or confirm treatment dates for your health insurer? Yes No

If you have a claim pending through ICBC or WCB, please inform the receptionist, who will provide different forms.

Last Name**	First Name**	Initial(s)**	Gender M F

****Please record your name exactly as written on your health card.**

Your Family physician:

Referral from: ☐ your family physician
☐ Other physician:

Birthdate Year / Month / Day	CareCard Number: _ _ _ _ _ _ _ _ _ _ _

Mailing Address:	City	Prov	Postal Code

Day Phone ❑OK to contact ❑OK to leave messages	Evening Phone ❑OK to contact ❑OK to leave messages

Office use only ❑ *Contact information currently on file has been confirmed and is accurate.*

Email address:	Cell Phone: ❑OK to contact ❑OK to leave messages

Please indicate the ways in which we can use your email address: ❑ All of the items listed OR:
❑ Appointment reminders
❑ Invoices
❑ Clinic Newsletter/Updates
❑ Personal letters and reports

So that we can better meet your needs, let us know if you have any of the following conditions:
❑ Environmental allergies
❑ Hard of hearing/deafness
❑ Latex allergy
❑ Limited mobility (walker, cane or wheelchair)
Paralysis: ❑ paraplegic
Paralysis: ❑ quadriplegic
Paralysis: ❑ other
❑ Poor vision/blindness
❑ Stroke
❑ Other:

Please read through this list of funders.
If your visit fees will be paid by one of these organizations, ***please circle the name and inform the receptionist, since additional information is required***:

Canadian Forces Base **Department of Veterans Affairs # K ______________________**
***Premium-assisted* MSP** **Royal Canadian Mounted Police # ______________________**
Unit: _______________ Collator: _______________________

Any appointment cancelled or missed without 24 hrs notice will be subject to a **$50 fee.**

Visit Costs

Each PT assessment and/or treatment	$62	
With MSP subsidy	$25	Maximum (*combined**) 10 visits/year
Massage assessment and/or treatment	$81/hr inc tax	
with MSP subsidy	$58/hr inc tax	Maximum (*combined**) 10 visits/year
CFB, DVA, RCMP	n/a	**Pre-approval required from funder**

i.e. maximum of ten visits/year for physiotherapy, chiropractic, massage, podiatry, and naturopathy and acupuncture.

Chart #

Consent for Treatment

It is the policy of the Sooke Evergreen Physiotherapy clinic to provide physical therapy treatments which are within the scope of physiotherapy practice as defined by the College of Physical Therapists of British Columbia (CPTBC); and/or provide massage therapy treatment within the scope of the BC College of Massage Therapy. **Please ask for copy of the scope of practice if you would like more details.**

We wish to create an open and balanced patient-therapist relationship. This assists us in providing you with the best possible health care. Your rights as a patient include:

- Your therapist will answer the questions you may have about your condition and provide information about the treatment being used, including risks and benefits.
- You may discontinue or refuse treatment at any time during your appointment. Your therapist will respect your wishes, and will choose alternate methods of treatment at your request.
- If you choose to receive treatment from other health care professionals, please tell your therapist. This assists in planning your treatments here.
- To help us maintain confidentiality, ***please tell the receptionist if you are expecting someone to contact you*** at the clinic.

Based on the above conditions, I consent to physical therapy treatment provided by:

❑ John Manley ❑ Roger Norris ❑ Jacqueline McAllister

Based on the above conditions, I consent to massage therapy treatment provided by:

❑ Dena McDonald

I also declare that all information on this form is accurate, ***and I will be responsible for any treatment costs,*** should my insurance carrier or funder fail to fulfill their financial agreement.

_______________________________ _______________ ____________________

Signature of Patient **Date** **Witness**

OR

____

Signature of Parent/Guardian

Print name of parent/guardian if applicable:

If contact information for parent/guardian is different from that given for the patient, please indicate the changes here:

We appreciate hearing from you about your experience at the clinic, especially if you were not pleased with something. And we value your telling others when your experience was positive!

If you were not referred by a physician, how did you hear about our clinic?

☐ Welcome Wagon ☐ Client who has been to the clinic:

☐ Sooke Lion’s phone book ad

☐ Yellow pages ☐ Other:

Client Name:_________________________________DOB:________________

Why do you ask so many questions on the medical information form?

There are many health-related factors that will affect the treatment your therapist chooses. Pain can be 'referred' from one part of the body to another; one example is that gallbladder pain will sometimes seem like right shoulder pain. Also, your therapist will be looking for anything that doesn't 'fit' with a musculoskeletal problem. If in any doubt, he/she will send you back to the doctor for further testing.

Patient Medical History

The receptionist will be happy to answer questions or assist you with this questionnaire.

Please *circle Y or N* for each of the following questions. Have you ever experienced or been diagnosed with:

Y N Headaches, dizziness, weakness, fainting

Y N Problems with coordination or balance

Y N Epilepsy

Y N Osteoporosis

Y N Arthritis or rheumatism

Y N High blood pressure

Y N Do you have a pacemaker?

Y N Allergies Please list:

Y N ***Unexpected*** weight change Gain: _______ lbs. Loss: ________ lbs.

Y N Head injury causing severe dizziness, loss of memory, vomiting, unconsciousness

Y N Heart trouble or cardiovascular difficulty

Y N Stroke

Y N Diabetes

Y N Surgery of any type within the last 18 months

Y N Women: are you pregnant, or think you may be pregnant?

Y N Any other new, unexpected or unusual symptoms:

Y N Cancer: Type of cancer and location:

Date of diagnosis: Type of Treatment(s):

Current status: ☐ in remission ☐ in treatment ☐ cancer-free for ________ years

Y N Have you ever been required to take steroids (e.g., Prednisone) for a long period of time?

Your Occupation(s): ______________________________

Hobbies and sports: ______________________________

Drugs, Food supplements and miscellaneous agents:

Y N Are you taking any prescription medications? Please list:

Y N Are you taking any non-prescription drugs? (sleeping pills, cold/allergy medication, herbs and supplements, etc.) Please list:

Y N Do you smoke? Packs/day:

Y N Do you drink alcoholic beverages? Approximately how much per week (average)?

On the diagram below, please circle the painful area(s):

Left Right

BACK

Right Left

FRONT

Date of Injury:

Injury Type: (Chronic, car accident, etc.)

Please indicate other health practitioners that you see.

❑ Acupuncturist ❑ Chiropractor ❑ Massage Therapist ❑ Other:

❑ Naturopath/Herbalist ❑ Osteopath ❑ Podiatrist or Chiropodist

Chart #

Pain Rating using the "Visual Analog Scale"
Please complete this form when you arrive for your appointment

Zero (0) at the left side of the page, indicates no pain at all. Ten (10) at the right side of the page indicates pain that is unbearable. Please make a single vertical mark on each line at the position that best indicates the amount of pain you feel. For example:

0 ——|———— 10

at its WORST in the past 24 hours:

0 (no pain) ________________ 10 (unbearable pain)

at its LEAST in the past 24 hours:

0 (no pain) ________________ 10 (unbearable pain)

AVERAGE:

0 (no pain) ________________ 10 (unbearable pain)

RIGHT NOW:

0 (no pain) ________________ 10 (unbearable pain)

Are you currently taking medication to help manage your pain? ❑Y ❑N

If Yes, do you know what type of medication and what dosage are you using?
❑"Over the counter" medication:
❑Aspirin ❑Tylenol Strength (i.e. mg/tablet) ________
❑Ibuprofen ❑Other:______________________
❑Anacin # tablets per day: _______

❑ Prescription medication: _________________________

Strength (i.e. mg/tablet) ______________ # tablets per day: _______

Date: ________________________

☞ **Patient / Parent/Guardian Signature:** _____________________________________ ☜

Scored by: ____________________

Chart # [ ]