MapleCare Physiotherapy Clinic

PATIENT INFORMATION		EMAIL ADDRESS:______________________________	
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	Province:	Postal Code:
Birth date (MM/DD/YYY): / /	Age:	☐ Male ☐ Female	
Home Phone: ( ) -	Work Phone ( ) -	Cell: Phone ( ) -	
Chose Clinic Because/ Referred to Clinic By ☐ Dr.:	☐ Family ☐ Friend		
☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:			

CARE PROVIDER INFORMATION	
Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr.	Regular Dr. Phone: ( ) -
Would you like a discharge report sent to your family physician?	Yes ☐ No ☐

IN CASE OF EMERGENCY		
Name of Local Friend or Relative:		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

CANCELLATION POLICY

We require a minimum of 24 hours notice for cancellation of an appointment. This will help us to book the time slot you have cancelled with another patient in need of our care.

Less than 24 hrs. cancellation or no show is subject to a fee of $50.00 Initials _________

PAYMENT POLICY

Payment is due in full by **cash, debit, Visa, MasterCard, or cheque** at the end of each treatment session. A receipt with all the required information shall be provided to you.

The physiotherapist at MapleCare Physiotherapy Clinic, may use techniques where the physiotherapist places his/her hands on your body. If you do not feel comfortable with any part of the treatment, please tell us immediately.

I understand the above and agree to give my consent to the health practitioner for assessment and treatment at MapleCare Physiotherapy Clinic. I understand that in order to provide safe treatment physiotherapist may need to communicate with my physician and/or other health care professionals, regarding my condition and treatment. I consent that ________________ (physiotherapist) can communicate with the following people regarding my health condition: ________________, ________________, ________________, and/or ________________.

I understand that MapleCare Physiotherapy Clinic practitioners and staff will collect, use and protect my personal information as set out in the clinic's privacy policy.

PATIENT /GUARDIAN SIGNATURE DATE

The health information requested on the following form will assist us in treating you safely. If you have any questions about the requested information, please feel free to ask.

PAST MEDICAL HISTORY FORM

Patient Name ____________________

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐
HEART DISEASE	**YES**	**NO**
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Myocardial Infarction	☐	☐
Rheumatic Heart Disease	☐	☐
Do you have a pacemaker	☐	☐
LUNGS	**YES**	**NO**
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity	☐	☐
Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐
OTHER CONDITIONS	**YES**	**NO**
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Cancer	☐	☐
Allergies	☐	☐
Pregnancy	☐	☐

Other conditions: ____________________

____

____

EXERCISE	WORK ACTIVITY	STRESS LEVEL
☐ None	☐ Sitting	☐ Low
☐ 1-2 x Week	☐ Standing	☐ Medium
☐ 3-4 x Week	☐ Light Labor	☐ High
☐ 5+ x Week	☐ Heavy Labor	

What types of exercise do you perform? : ____________________
:

Are you taking any seizure medication? ☐YES ☐NO If yes list name: ____________________

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐YES ☐NO If yes list name: ____________________

List all medications you are currently taking: ____________________

List all surgeries : ____________________

Are you pregnant? ☐ YES ☐ NO What week?: __________

Have you had any Auto Accidents ☐ YES ☐ NO If yes list body part and date.: ____________________

Are you receiving treatment from other health care professionals? ☐ YES ☐ NO Where ____________________

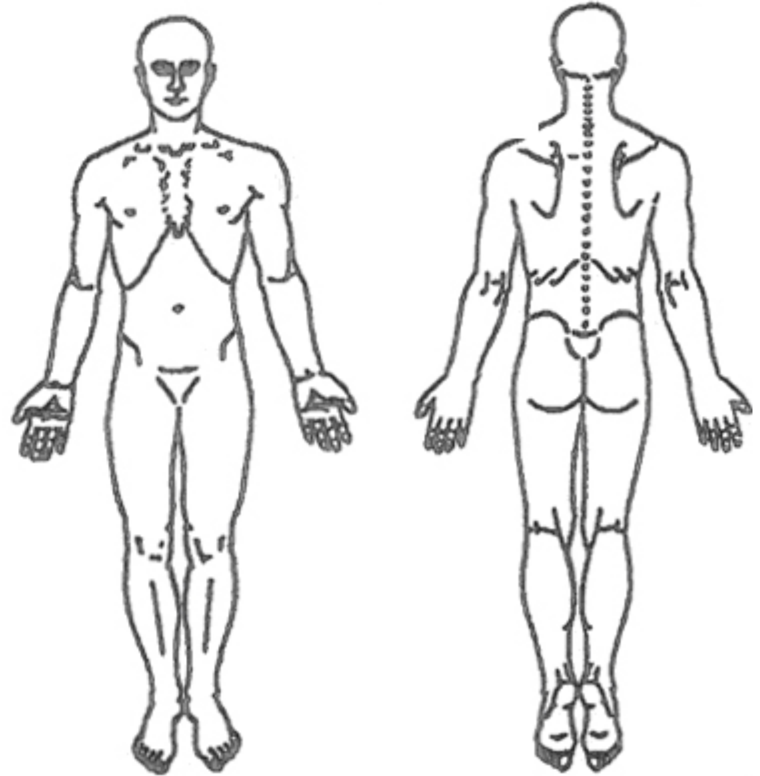
Have you had Physiotherapy or Massage Therapy before? ☐ YES ☐ NO Where:

____________________ Signature of Patient, Parent, Guardian, Personal Representative

____________________ Date

Pain and Symptom Status Report

Name: ______________________________ **Date:** ____________________



Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing

Ache	Burning	Numbness
MMM M	— — — — —	O O O O O O O

Pins and Needles	Stabbing	Other
▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫ ▫	/ / / / / / / / / /	x x x x x x x

Chief Complaint and Visual Analog Scale

My Chief Complaint is: ______________________________

Date First Symptom of your problem occurred on. ____________

2nd Complaint ______________________________

3rd Complaint: ______________________________

Please circle on the scale below to indicate your __CURRENT__ level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Please circle on the scale below to indicate your __AVERAGE__ level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Please circle on the scale below to indicate your __WORST__ level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Additional Comments ______________________________