MAPLECARE PHYSIOTHERAPY & NEURO REHAB CENTRE

1173 Wellington St. West, Ottawa, ON K1Y 2Y9 – (613) 695-1111
203-1637 Woodroffe Ave., Nepean, ON K2G 1W2 – (613) 691-1515
1395 Bank Street, Ottawa, ON K1H 8N1 – (613) 627-0007
W: www.maplecarephysiotherapy.com E: info@maplecarephysiotherapy.com

NEW PATIENT FORM

Treatment Location: ----Select----

PATIENT INFORMATION

Patient's Full Name _____ Date of Birth (mmddyy) _____

Address _____ City _____ Province _____ Postal Code _____

Gender ☐ Male ☐ Female Telephone (H)_____ (W)_____

Email _____

Please do not use work email address. By providing your email, you are consenting to email communication from MapleCare such as appointment reminders, statements, invoices, exercise instructions, newsletters & promotional messages. If you wish not to receive them, please inform us.

Cell # *(Necessary for phone & Text reminders)* _____

MapleCare staff may leave phone messages at provided numbers for confirmation or changes to your scheduled appointments.

How did you hear about us?

☐ Google, online ads, website
☐ Facebook/Instagram
☐ Street sign
☐ Flyer
☐ Newspaper: _____
☐ Referred by friend or family: _____
☐ Others: _____
☐ Referred by Dr: _____

EMERGENCY CONTACT

Full Name _____ Relationship _____ Telephone _____

CARE PROVIDER INFORMATION

Family Doctor's Name _____ Telephone _____

Referring Doctor's Name _____ Telephone _____

INFORMED CONSENT (Please read completely)

- MapleCare Physiotherapy Clinic is my health information custodian.
- I give consent to the physiotherapists at MapleCare Physiotherapy Clinic for assessing and treating my condition(s) who may use techniques that require them to place their hands on my body.
- I understand that in order to provide safe treatment, my physiotherapist may need to communicate with my physician and/or other health care professionals regarding my condition and treatment, for which I give consent.
- A minimum of 24-hour notice is required for cancelling an appointment to accommodate other patients in need of care. **I am subjected to a fee of $50.00 for no-show or cancellations made in less than 24 hours.**
- Payment is due in full by cash, debit, credit or cheque for every visit. A receipt with all the required information will be provided.

Please write Patient/Guardian Full Name below which serves as electronic signature:

NAME (Patient/Guardian) _____ **DATE** _____

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Patient's Full Name _____ Date of Birth _____

CHIEF COMPLAINT

My chief complaint is _____

How long have you been dealing with this pain/complaint? _____

2nd complaint: _____ 3rd complaint: _____

Please choose the scale below to indicate your **CURRENT** level of pain:

No Pain ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ As painful as it gets

PAST MEDICAL HISTORY FORM

Please select any of these conditions that you may have had in the past

- ☐ Hypertension
- ☐ Heart Attack
- ☐ Atherosclerotic Disease
- ☐ Rheumatic Heart Disease
- ☐ Pacemaker or any other electrical implants
- ☐ Asthma
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Epilepsy or seizures
- ☐ Gout
- ☐ Fibromyalgia
- ☐ Diabetes
- ☐ Impaired wound healing
- ☐ Hearing Loss
- ☐ Poor Eyesight
- ☐ Fainting
- ☐ Cancer
- ☐ Allergies to adhesives or metal
- ☐ Pregnancy
- ☐ Hepatitis B, C, HIV, or any other infectious diseases
- ☐ Other conditions:

_____

EXERCISE LEVEL

☐ None ☐ 1-2x week ☐ 3-4x week ☐ >5x week

WORK ACTIVITY

☐ Sitting ☐ Light labour ☐ Standing ☐ Heavy labour

STRESS LEVEL

☐ Low ☐ Medium ☐ High

What types of exercise do you perform? _____

Do you have fear of needles? ☐ Yes ☐ No

Are you taking any anticoagulants (i.e. Aspirin, blood thinners)? ☐ Yes ☐ No

Are you taking any antibiotics for an infection? ☐ Yes ☐ No

List all medications you are currently taking: _____

List all surgeries you have had: _____

Have you had any auto accidents? ☐ Yes ☐ No If yes, please list the injured body part(s) and date of accident:

_____

Are you receiving any treatment from other healthcare professionals? ☐ Yes ☐ No If yes, where: _____

Have you had any physiotherapy treatment or massage therapy before? ☐ Yes ☐ No If yes, where: _____

Please write Patient/Guardian Full Name below which serves as electronic signature:

NAME (Patient/Guardian) _____ **DATE** _____

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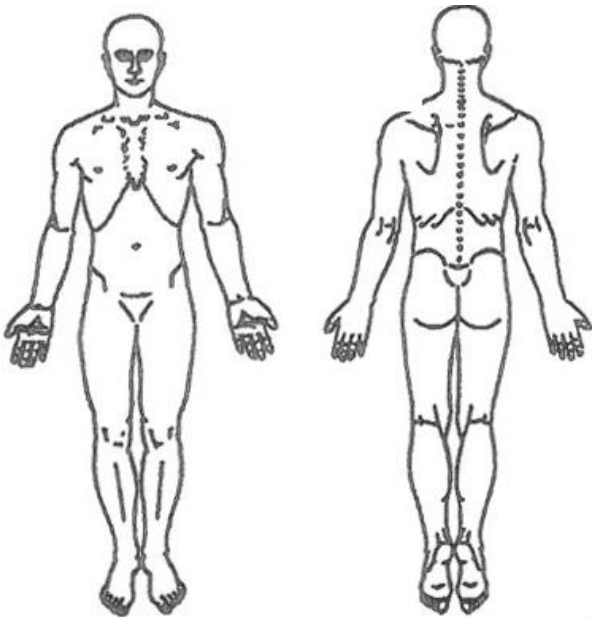
Patient's Full Name _____ Date of Birth _____

PAIN AND SYMPTOMS STATUS REPORT

Please write the location of pain in the body and select the severity level of the pain that the patient is experiencing:

Type of Pain	*Location of Pain*	*Severity Level*
Ache	_____	--Select--
Burning	_____	--Select--
Numbness	_____	--Select--
Stabbing	_____	--Select--
Pins & Needles	_____	--Select--
Other: _____	_____	--Select--



(For Motor Vehicle Accidents patients only)

Type of Photo ID _____Verified by _____ Date (mmddyy) _____

Date of Accident (mmddyy) _____ Do you have any private healthcare coverage? ☐ Yes ☐ No

Name of Insurance Company _____ Motor Vehicle Billing Insurance _____

Policy Number _____ Claim Number _____

Insurance Adjuster Name _____ Phone _____ Fax _____

It is necessary to have all insurance information filled in correctly. Any misinformation may result in invoices being forwarded to the client.

INFORMED CONSENT (Please read completely)

- If not approved for funding through an MVA protocol, I understand that I am responsible for any fees incurred and any treatment fees that are NOT covered by my insurance company. Accounts that are 6 months old will be sent to our collections agency. For fee details, please see our front desk staff for more information.
- I am aware of the 24-hour notice requirement to cancel an appointment. I understand that if I fail to attend an appointment or cancel in less than 24 hours, a fee of $50 will be applied to my account which cannot be billed to my insurance coverage.
- I am providing valid credit card information below and authorization for use in case payment of account is required by myself:
  Credit Card Type: ☐ MasterCard ☐ Visa ☐ AMEX ☐ Others: _____

  Card Number _____ Expiry Date (mmyy) _____ /_____

Please write Patient/Guardian Full Name below which serves as electronic signature:

NAME (Patient/Guardian) _____ **DATE** _____

CLEAR PRINT LOCK & SAVE