WELCOME!!!

Please Print Clearly and Fill Out This Form Completely. Return to Our Receptionist As Soon As Completed.

PATIENT INFORMATION:

LAST NAME:_____ **FIRST NAME:**_____ **SEX:** ❑**M** ❑**F**

PARENT/GAURDIAN NAME:_____

MAILING ADDRESS:_____ **CITY:**_____ **POSTAL CODE:**_____

****E-MAIL ADDRESS****:_____

HOME PHONE: ( )_____ **AGE:**_____ **Date of Birth:** _____ / _____/ _____
CELL PHONE: _____ *Month Day Year*

EMPLOYER:_____ **PHONE: ( )**_____**EXT**_____

OCCUPATION:_____ **MAY WE CALL YOU AT WORK?** ❑**Y** ❑ **N** **HOURS:**_____

WHO IS YOUR FAMILY DOCTOR?_____ Phone (if not local)_____

DO YOU SEE ANY OTHER MEDICAL SPECIALISTS? If yes, who and for what problem? _____
_____
_____

IN CASE OF EMERGENCY:

WHO SHOULD BE NOTIFIED?_____**RELATIONSHIP:**_____**PHONE ( )**_____

WHAT MADE YOU DECIDE TO COME TO OUR CLINIC?

We need your help to make sure we allocate our promotional budget to the best resources. Please tell us what made you decide to choose our clinic instead of another one:

❑ Your doctor/specialist told you to come
Who is your Doctor?_____

❑Your Friend/Relative told you about this clinic
Who is your friend/relative? _____

❑ You heard our ad on the radio
Which station?_____

You saw our ad in the: ❑Yellow Pages ❑Large Print Phone Book ❑ Newspaper (Which One?):_____
❑Magazine (Which One?):_____

❑You saw our sign ❑You saw us at an event
Which event?_____

❑Google Search/Website ❑Social Media (i.e. facebook)

❑You have been a patient here before and you decided to come back

❑ Other (please tell us):_____

PLEASE TURN PAGE OVER…We have questions about your health……

we-fix-u.com YOUR PHYSIOTHERAPY & FOOT HEALTH CENTRES

Health Consent and Office Policies

Cancellation Policy: Patients who fail to provide **2 business days' notice** for cancellation or change in scheduled appointment are subject to a cancellation fee. This fee also applies to patients who do not attend their scheduled appointment. All subsequent missed/cancelled/changed appointments will be charged the full appointment fee, without notice as per our policy. This policy also applies to Motor Vehicle Accident, DVA, OHIP and WSIB patients *(your insurance company is not responsible for this fee)*

INITIAL HERE_____

Our Current Fee Schedule *(subject to change without notice):*

SERVICE	FEE
Physiotherapy Initial Assessment and Treatment (per incident)	**$85**
Physiotherapy Re-Assessment *(same incident- more than 3 months between appointments, but less than one year)*	**$75**
Physiotherapy Subsequent Visits	**$65**
Chiropody Initial Assessment (per incident)	**$70-$90**
Chiropody Re-Assessment *(same incident – more than 3 months between appointments, but less than one year)*	**$60-$75**
Chiropody Subsequent Visits	**$48-$65**
Custom Made Orthotics	**$495**
Massage Therapy 30 Min Session	**$55 + HST**
Massage Therapy 60 Min Session	**$85 + HST**

Patient Consent:

- ☐ I understand that I am financially responsible for all charges whether covered by my health insurance plan or not. I understand that service fees are payable at the time the service is provided.
- ☐ I consent/allow We-Fix-U to release/request all medical information regarding my diagnosis, treatment and prognosis to/from my family physician, referring physician or consulting specialist
- ☐ I hereby allow/consent to examination and treatment by a We-Fix-U healthcare provider
- ☐ I allow/consent photographs to be taken of the treatment areas for the purpose of monitoring results

Patient Name:_____ Signature:_____
Date:_____

Patient's Signature (Guardian):_____ D.O.B: _____ Date Signed:_____

PATIENT GENERAL MEDICAL HISTORY

What problem(s) would you like us to evaluate and treat today?:_____
_____
_____
_____

How long has this been a problem?:_____

When is this problem most bothersome?_____
_____

Is this problem getting: worse / better / same? **(Circle one)**

Have you had medical treatment for this problem? ❑Y ❑N
If yes, where did you receive this treatment?_____
_____

Have you had previous x-rays, MRI, ultrasound, CT Scan, or any other imaging or diagnostic testing for this problem?
❑Y ❑N

If yes, what date did you have them taken?:_____

At which facility were these images/tests performed?
❑NHH ❑Blue Water Imaging (Port Hope)
❑Other:_____

Describe all attempted treatments or home remedies:_____
_____

What do you expect (what are your goals) from your treatment at our clinic?_____
_____
_____
_____

What is your <u>current:</u>
Height:_____ Weight:_____ Shoe size:_____

How much are you on your feet at work?: (Circle one)
20% 40% 60% 80% 100%

What type of footwear do you wear to work?:
❑ Safety shoe/boot ❑Athletic ❑Dress ❑Sandal ❑Other

Check any sports or activities you participate in regularly:
❑ Walking ❑ Running ❑ Aerobics / Aqua Fit ❑ Golf
❑ Hockey ❑ Soccer ❑ Racquet sports ❑ Skiing
Other:_____

Please list your current <u>prescription</u> medications: If you take too many to list, we can photocopy your personal list.

1._____ 2._____
3._____ 4._____
5._____ 6._____
7._____ 8._____

Do you <u>have</u>, or have you <u>ever been</u> treated for:
(Check all that apply)

❑ Diabetes: Type 1 Type 2 How Long?_____
❑ Heart trouble ❑ Tuberculosis ❑ Hepatitis
❑ Thyroid problem ❑ Liver Disease ❑ HIV / AIDS
❑ Urinary problem ❑ Blood Disease ❑ Stroke
❑ Stomach/bowel trouble ❑ Depression ❑ Anxiety
❑ High blood pressure ❑ Bone Disease ❑ ↑Cholesterol
❑ Arthritis ❑ Cancer ❑ Epilepsy
❑ Shortness of breath ❑ Skin Disorder ❑ Back Problems
❑Hip/knee replacement ❑Fibromyalgia
❑Other_____

Have you had any surgeries? If so, for what?_____
_____
_____

Do you have <u>allergies</u> to:

Penicillin, Sulfa, Erythromycin?	❑Y	❑N
Narcotics? (codeine, demerol, morphine)	❑Y	❑N
Local anesthetics? (Xylocaine, Novocaine)	❑Y	❑N
Pain remedies? (Tylenol, aspirin, etc.)	❑Y	❑N
Adhesive tapes/band-aids?	❑Y	❑N
Latex?	❑Y	❑N
Environmental allergens?(dust,pollen)	❑Y	❑N
Other drug, medication, treatment?	❑Y	❑N

↳ Indicate allergen(s):_____

Are you currently pregnant or nursing? ❑Y ❑N

Do you have a pacemaker? ❑Y ❑N

☺ THANK YOU PLEASE RETURN THIS FORM TO THE RECEPTIONIST ☺