Binbrook Chiropractic & Physiotherapy 3064 Highway 56 Binbrook, ON L0R1C0

HEALTH HISTORY FORM

For Your Information:
An accurate health history is important to ensure that it is safe for you to receive a treatment. If your health status changes in the future, please let us now. All information gathered for this treatment is confidential except as required or allowed by law or to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____ Preferred Name (if any): _____

Address: _____ Today's Date: _____

City: _____ Postal Code: _____

Telephone Number (Home): _____ (Work): _____ (Cell):_____

E-mail Address: _____

Date of Birth: _____/_____/_____ Gender: M / F Occupation: _____
Month Day Year

Primary Care Physician: _____ Address: _____

Previous Chiro / Physio / Massage Care:_____ Last seen:_____

For what condition:_____ Results:_____

MVA or WSIB Claim number: _____

Emergency Contact Name and Phone Number:_____

Health History: please indicate conditions you are experiencing, or have experience.

Respiratory
- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema
- ☐ other _____

Cardiovascular
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ CCHF
- ☐ heart attack
- ☐ phlebitis
- ☐ stroke/CVA
- ☐ pacemaker or similar device
- ☐ other _____

Family History
- ☐ arthritis
- ☐ cancer
- ☐ diabetes
- ☐ heart disease/stroke

Other Conditions
- ☐ diabetes: onset _____
- ☐ allergies _____
- ☐ cancer
- ☐ arthritis
- ☐ migraines &/or headaches
- ☐ loss of sensation
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss
- ☐ skin conditions
- ☐ hepatitis
- ☐ TB
- ☐ HIV
- ☐ other _____

_____

Cigarette/Tobacco Consumption
- ☐ yes – amount _____/day
- ☐ no

Women
- ☐ pregnant: - due: _____

Soft Tissue/Joint Discomfort
- ☐ neck
- ☐ low back
- ☐ mid back
- ☐ upper back
- ☐ shoulders
- ☐ arms
- ☐ hands
- ☐ hips
- ☐ legs
- ☐ knees
- ☐ feet
- ☐ other _____

Rate your General Health
- ☐ above average
- ☐ average
- ☐ below average

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Are you currently taking any medications? _____

What is your **Current complaint?** _____

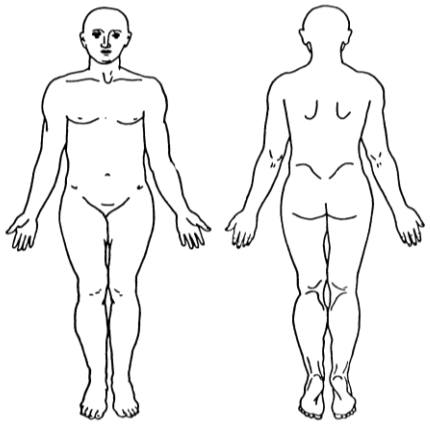
Has this condition occurred before? Yes/No

When did this condition begin? _____

Is the condition: ☐ Job-related ☐ Auto-related
☐ Fall ☐ Home Injury ☐ Other: _____

Date of Accident: _____

What happened? _____



Please mark on the diagram the area of your discomfort and any radiation of pain.

Circle the grade to indicate the severity of your pain:

LEAST 0 1 2 3 4 5 6 7 8 9 10 WORST

Have you gone for any x-rays, ultrasounds, MRI's etc. for ***this injury/problem?*** YES / NO

If YES, where? _____and approximately when? _____

Surgeries/Major Injuries (Nature/Date): _____

Presence of internal pins, wires, artificial joints, special equipment, etc._____

What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking
☐ Lying Down ☐ Cold ☐ Dampness ☐ Other: _____

What relieves your condition? ☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication
☐ Other: _____

Is it getting: ☐ Worse ☐ Constant ☐ Comes/Goes ☐ Better

Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb
☐ Burning ☐ Intermittent ☐ Constant

Does the pain radiate anywhere? ☐ No ☐ Arm (L or R) ☐ Leg (L or R) ☐ Other: _____

When does it hurt? ☐ Morning ☐ Evening ☐ wakes me up at night ☐ Other: _____

Please describe how it feels when this problem is at its worse: _____

How did you hear about Binbrook Chiropractic & Physiotherapy? ☐ Referral from Doctor ☐ Friend/Patient ☐ Sign ☐ Flyer/Advertisement ☐ Other: _____

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Binbrook Chiropractic & Physiotherapy
Physiotherapy Informed Consent Form

Please read the following statements and sign below. I understand that if I have any questions, I may discuss them with the physiotherapist prior to signing below.

I must inform my physiotherapist of any contagious or infectious condition that I might have.
I understand that I need to express all of my health concerns (both current and past) to my therapist.
I consent to an examination and treatment performed by a licensed physiotherapist. The results of the assessment will assist the physiotherapist in determining the appropriate physical treatment to meet my specific needs and goals.
I may stop the assessment or treatment procedure(s) at any time, during or after a session. The examination is mandatory and required to assist the physiotherapist in constructing a treatment plan.

_____ _____ _____
Signature of Client **DOB (MM/DD/YYYY)** **Date (MM/DD/YYYY)**

_____
Printed name of Client

I understand that my treatment in this clinic may involve the use of:
Various physical and electrical modalities, such as heat, ice, electrical and/or ultrasound
Acupuncture (pre-sterilized and disposable needles only)
Stretching, soft tissue techniques, mobilization and/or manipulation of joints and tissues
Exercise programs aimed at mobility, strength and function

I understand that there are some inherent risks to treatment including but not limited to pain, during and/or following treatment; strains/sprains; bruising; fainting; infection and electric shock. I understand that it is my responsibility to inform the therapist should I experience any unusual symptoms.
I do not expect the practitioner to be able to anticipate and explain all possible risks and complications.
I understand that if at any time I am not comfortable with, and/or do not understand the purpose of any treatment procedure I will ask the physiotherapist for further explanation/information.
I understand that the clinic may send a report(s) as appropriate to the practitioner who referred me to the clinic for treatment; or to the doctors involved in my care.

My signature below indicates that I have had an opportunity to discuss my case with the physiotherapist and that I understand the information provided above and/or by the physiotherapist.

_____ _____ _____
Signature of Client **DOB (MM/DD/YYYY)** **Date (MM/DD/YYY)**

If under 16 years of age, the following section of the consent form must be completed by a parent or guardian before treatment can be initiated.

I have read and fully understand all of the above information and give my permission to have

_____ assessed and /or treated.
Printed name of Client

_____ _____ _____
Printed Name of parent/guardian **Signature of parent/ guardian** **Date**

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PRIVACY POLICY

PATIENT DISCLOSURE FORM: FOR COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Privacy of your personal information is an important part of providing you with quality Physiotherapy care. We understand the importance of protecting your personal information, and are committed to collecting, using and disclosing your personal information responsibly. We also try to be as open as possible about the way we handle your personal information. It is important to us to provide this service to our patients.

In this office, Denise Clarke acts as the Privacy Information Officer.

All staff members who come in contact with your personal information are aware of the sensitive nature of the information that you have disclosed to us. They are all trained in the appropriate uses and protection of your information.

Attached to this consent form, we have outlined what your office is doing to ensure that:

- Only necessary information is collected about you;
- We only share your information with your consent;
- Storage, retention and destruction of your personal information complies with existing legislation and privacy protection protocols;
- Our privacy protocols comply with privacy legislation, standards or our regulatory body, the College of Physiotherapists of Ontario, and the law

Do not hesitate to discuss our policies with any member of our office staff. Please be assured that every staff person in our office is committed to ensure that you receive the best quality care.

PRIVACY POLICY

How Our Office Collects, Uses and Discloses Patients' Personal Information

Our office understands the importance of protecting your personal information. To help you understand how we are doing that, we have outlined here how our office is using and disclosing your information.

This office will collect, use and disclose information about you for the following purposes:

- To deliver safe and efficient patient care;
- To identify and to ensure continuous high-quality service;
- To assess your health needs;
- To provide health care;
- To advise your treatment options;
- To enable us to contact you;
- To establish and maintain communication with you;
- To communicate with other treating health-care providers;
- To allow us to efficiently follow-up treatment and care;

- For teaching and demonstrating purposes on an anonymous basis;
- To complete and submit claims for third party adjudication and payment;
- To comply with legal and regulatory requirements, including the delivery of patients' charts and records to the College of Physiotherapists of Ontario in a timely fashion, when required, according to the provisions of the Regulated Health Professionals Act;
- To prepare materials for the Health Profession Appeal and Review Board (HPARB);
- To invoice for goods and services;
- To process credit card payments;
- To comply generally with the law;

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By signing the consent section of this Patient Consent Form, you have agreed that you have given your informed consent to the collection, use and/or disclosure of your personal information; we will seek your approval in advance.

Your information may be accessed by the regulatory authorities under the terms of the Regulated Health Professions Act (RHPA) for the purpose of the College of Physiotherapists fulfilling its mandate under the RHPA, and for the defense of a legal issue.

Our office will not under any conditions supply your insurer with your confidential medical history. In the event this kind of request made, we will forward the information directly to you for review, and for your specific consent.

When unusual requests are received, we will contact you for permission to release such information. We may also advise you if such a release is inappropriate.

You may withdraw your consent for use or disclosure of your personal information, and we will explain the ramifications of that decision, and that process.

PATIENT CONSENT

I have reviewed the above information that explains how your office will use my personal information, and the steps your office is taking to protect my information.

I agree that Jackeline Okimi and/or MohammadRahil Shaikh, use and disclose personal information about me as set out above in the information for Binbrook Family Chiropractic.

_____ _____

Signature Print Name

_____

Date