Health Centre of Milton
420 Main St. E. Unit 102 &103 Milton, Ontario, L9T 1P9
P: 905-878-8131 F: 905-878-9167

NEW PATIENT

Mr./Mrs./Miss./Ms: _____ First Name: _____ Surname: _____

Birth Date: (day/month/year)_____/_____/_____ Age: _____

Address: M/F:

City/Town: Postal Code:

Phone Number: (home) (Cell) (Work)

May we leave a message when calling you? Yes ☐ No ☐

E-mail (Correspondence and Newsletters):

☐ Please check this box if you DO NOT want to receive e-mails for newsletters and events.

Occupation:

Employed by:

Who referred you to our clinic? Or how did you hear of us: _____

Height: Weight: Number of Children:

Have you had Orthotics Previously?

Family M.D. Phone Number:

Is your injury due to: Motor Vehicle Accident ☐ Work Place Injury ☐

I understand that any insurance coverage besides WSIB and MVA is an arrangement between the insurance company and myself. Furthermore, I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I consent the HCM to confirm treatment dates should my EHC insurance inquire.
I consent to sharing my personal health information with any treating practitioners/HCM staff involved in my care. Please note that all information provided will be kept confidential unless allowed or requested by law. Your written permission will be required to release any information. **I understand that 24 hours is needed to cancel an appointment or full fee will apply.**

DATE: _____ SIGNATURE: _____

For RCMP Officers ONLY

Health Plan Card I.D: **Unit:** **Division:** **Collator:** .

Updated:_____

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Please circle **(O)** any **current** conditions or symptoms.
Please check **(√)** beside **past** conditions or symptoms.

Name:_____
Date:_____

General Symptoms †
Loss of consciousness
Blackouts
Headaches/Migraines
Fever
Sweats
Fainting
Dizziness
Clumsiness
Convulsions/Tremors
Loss of sleep
Loss of weight
Depression
Fatigue
Nervousness
Numbness/Pain or Tingling

Muscle & Joint
Arthritis
Weakness/Loss of strength
Swollen joints
Back pain
Shoulder pain
Arm/forearm pain
Elbow pain
Wrist pain
Hand pain
Knee/leg pain
Painful tailbone
Foot trouble
Stiff Neck
Sciatica
Scoliosis

Skin
Sensitive skin/loss of sensation
Rashes/eruptions/itching
Acne
Cold sores
Infectious skin condition
Bruise easily
Hives
Eczema/psoriasis
Boils

Gastrointestinal
Blood in stool
Vomit
Colitis/Crohn's
Constipation
Diarrhea
Difficult digestion/indigestion
Poor appetite/excessive hunger
Belching or Gas
Vomit (blood?)
Food allergies:_____
Gall bladder troubles
Heart burn
Jaundice/Liver trouble
Nausea
Pain over stomach
Intestinal worms
Ulcers

Eyes/Ear/Nose/Throat
Blurred vision
Double vision
Eye pain
Deafness
Ear issues:_____
Frequent colds
Enlarged glands
Enlarged thyroid
Nose bleeds
Sinus infection
Difficulty swallowing
Speech problems

Respiratory
Asthma
Anaphylaxis
Chest pain
Chronic cough†
Bronchitis
Spitting up blood‡
Spitting up phlegm
Wheezing
Shortness of breath
Emphysema
Infectious respiratory condition
Family History

Cardiovascular
Pain over heart
Poor circulation
Swelling of extremities
High/Low blood pressure
Hardening of arteries
Varicose veins
Heart or blood disease: _____
Presence of pacemaker
Heart attack/stroke
Family History

Other Conditions
Epilepsy
Herpes
Hepatitis
Plantar warts
TB
HIV, AIDs
Diabetes: ☐Type 1 ☐Type 2
Gout
Fibromyalgia
Multiple Sclerosis
Parkinson's
Hemophilia
Osteoporosis
Other: _____

Women Only
Breast tenderness/swollen breasts
Cramps or backache
Excessive flow
Irregular cycles
Menopausal (hot flashes, mood swings)
Painful menstruation
Pregnant-Due Date:_____
# of children _____
Hysterectomy

Gentourinary
Trouble urinating
Blood in urine
Kidney infection
Bed wetting
Prostate trouble

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Name:_____ **Date:**_____

Please indicate if you have/had/been any of the following:

Falls/fractures/dislocations date: _____
Pins/plates/rods date: _____
Surgery date: _____
Accidents date: _____
Hospitalized date: _____
Knocked unconscious date: _____

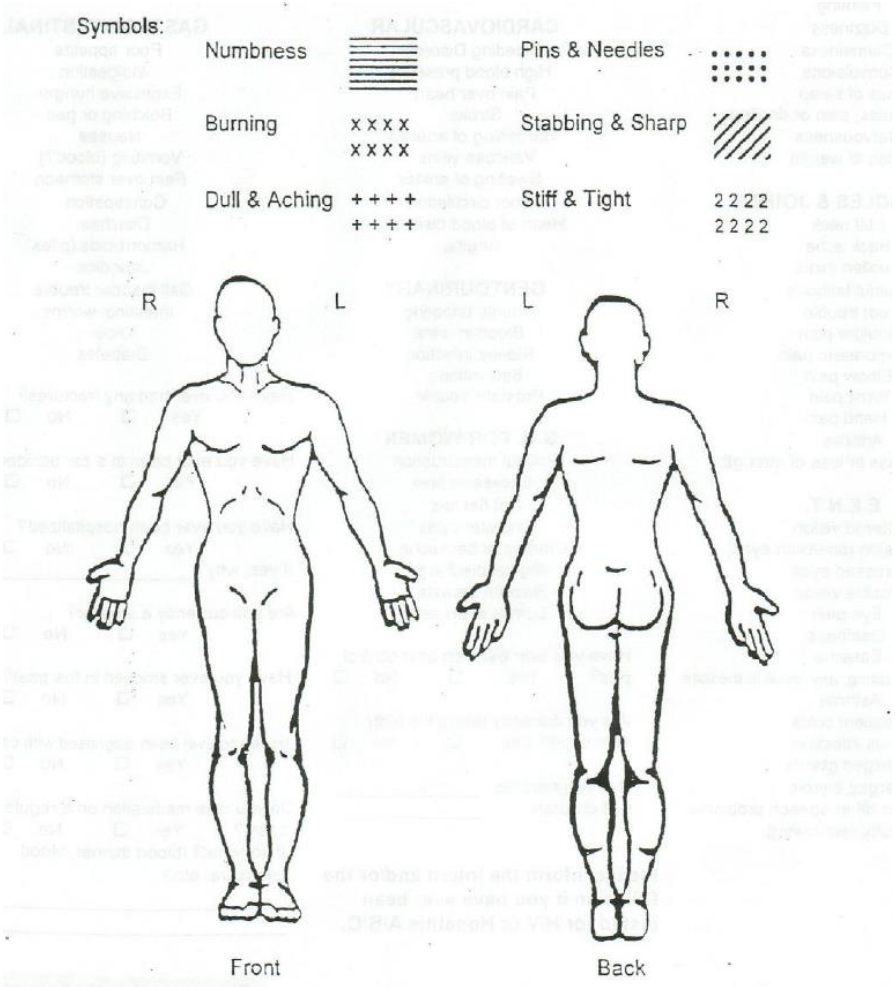
How is your general health? _____

Are you currently a smoker?	Yes	No
Have you ever smoked in the past?	Yes	No
Have you ever been diagnosed with cancer?	Yes	No
Do you take medication on a regular basis?	Yes	No

If so, what? (blood thinner, blood pressure, etc) _____

Area of Major Complaint:_____

In the diagram provided below, please mark the areas on your body which you feel best represent the pain(s) or sensation(s) you are experiencing. Please include *all* areas. Use the symbols provided below.



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Physiotherapy Informed Consent Form

Please read the following statements carefully and sign below

I hereby consent to an assessment and treatment performed by a licensed Physiotherapist. The results will assist the Physiotherapist in determining the appropriate treatment to meet my specific goals. I understand that my treatment in this clinic may include: physical and electrical modalities (e.g. heat, ice, TENS, interferential current, Laser, Acupuncture), manual hands-on therapy, and active exercises aimed at mobility, strength, and function.

I understand that discomfort may occur following treatment. I understand that it is my responsibility to contact my therapist should I experience any unusual symptoms. 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 clarification.

I understand that results are not guaranteed and that I may withdraw this consent and discontinue the assessment or treatment at any time.

I understand that for the provision of professional services the cost of the assessment and treatment/ services provided to me will be:

Physiotherapy Initial Assessment (up to 1 hour): $90
Physiotherapy Subsequent Visit (up to 20 minutes hands-on treatment): $63
Physiotherapy Extended Visit (up to 40 minutes): $95
Physiotherapy Re-Assessment/New Injury (up to 1 hour): $75

I have read, understood, and had opportunity to ask questions regarding this consent form. I intend this consent to cover the entire course of assessment/treatment for my present and future physiotherapy care.

My signature below indicates my understanding of all the above information.

_____	_____	_____
Patient Name (Please Print)	Patient Signature	Date

_____	_____
Physiotherapist Name	Physiotherapist Signature