MR. MRS. MS. MISS. M. MME. DR.	FULL NAME:
ADDRESS:	HOME PHONE:
APT. # CITY:	WORK PHONE:
POSTAL CODE:	CELL PHONE:
OCCUPATION:	BIRTH DATE (DD/MM/YY) / /
EMAIL ADDRESS: ☐ I consent to receiving email communication from Nova Physiotherapy, including email appointment reminders.	
EMERGENCY CONTACT:	PHONE:

FAMILY DOCTOR:	REFERRING DOCTOR:
AREA OF BODY INJURED/IN PAIN:	
DATE OF INJURY/ONSET OF EPISODE:	
ARE YOU OFF WORK BECAUSE OF YOUR INJURY? YES OR NO	(*if yes*) LAST DAY OF WORK (DD/MM/YY) / /

Coverage Information:

Are you here as a result of a Motor Vehicle Accident? YES NO	
(*if yes*) **YOUR** AUTOMOBILE INSURANCE COMPANY:	
INSURANCE ADJUSTOR:	PHONE #: FAX#:
CLAIM/POLICY #:	DATE OF ACCIDENT (DD/MM/YY) / /

Is your injury covered by Workers Compensation? YES NO		
(*if yes*) CLAIM #:	HEALTH CARD #:	
EMPLOYER:	DATE OF ACCIDENT (DD/MM/YY): / /	
EMPLOYER CONTACT NAME:		PHONE #:

**If for any reason your WCB or MVA Physiotherapy Claim is denied, you will be responsible to pay the outstanding balance on your account.*

Do you have private medical insurance? (ie. Blue Cross, Green Shield, etc) **YES NO**	
INSURANCE COMPANY:	POLICY HOLDER:
POLICY/PLAN NUMBER :	ID NUMBER :
PERCENTAGE COVERED: %	TO MAXIMUM OF: $

Payment Notice: *M.S.I./Medicare does not cover Private Physiotherapy or Massage Therapy in Nova Scotia. You, or your medical insurance company, are directly responsible for payment of services provided. We direct bill insurance companies where the policy allows for it. It is your responsibility to keep track of the treatments attended so you do not exceed your coverage. Any amount not covered by the insurance company will be your responsibility. Payment must be made after each session.*

Cancellation/Missed Appointment Policy

Your time is reserved for you. Should you need to cancel or reschedule an appointment, a minimum of **24 hours notice** is required, otherwise YOU will be charged:

- **a $25.00 fee for a missed PHYSIOTHERAPY/CHIROPRACTIC/DIETETIC appointment.**
- **half the normal fee for a missed MASSAGE THERAPY appointment.**

Health plans, motor vehicle insurers and WCB **DO NOT** pay for missed appointments. These fees are your responsibility.

Signature:_____ ***Date:***_____

Consent and Release of Information

Nova Physiotherapy believes that it is important to establish and maintain clear lines of communication with all parties involved in the successful rehabilitation of your injury. As a result, information relating to your treatment progression and treatment plans may be shared with your physician, case manager, employer and/or third party payer.

I, _____(**please print your name**), do consent to being treated/assessed by Nova Physiotherapy. I hereby authorize the release of my assessment or progress notes, or any other medical information to my: **(Please fill in appropriate names)**

_____ (Family Physician)	_____ (Insurance Company)
_____ (Workers Compensation Board)	_____ (Lawyer)
_____ (Physiotherapist)	_____ (Medical Specialist)
_____ (Employer Representative)	_____ (Other)

Or, ☐ I accept responsibility for ensuring that my report is taken to the appropriate party/appointment.

Signature:_____ ***Date:***_____

How did you hear about us? (Please circle one)

Rink Advertisement	Yellow Pages	Signage	Google	Running Race
Friend/Family	Doctor	Brochure	Website	Other:_____

Medical History Information

Please indicate any of the following conditions that **you** have:

- ❒ Arthritis
- ❒ Hernia
- ❒ Diabetes
- ❒ Depression
- ❒ Thyroid Condition
- ❒ Osteoporosis
- ❒ Dizziness/Fainting
- ❒ Smoking History
- ❒ Low/ High Blood Pressure
- ❒ Reynaud's
- ❒ Heart Condition
- ❒ Sleeping Problems
- ❒ Chest Pain
- ❒ Cough
- ❒ Pacemaker
- ❒ Vision Difficulties
- ❒ History of Cancer
- ❒ Swallowing Difficulties
- ❒ Allergies to tape/latex
- ❒ Slurred Speech
- ❒ Any Allergies
- ❒ Memory Problems
- ❒ Epilepsy/Seizures
- ❒ Balance Problems
- ❒ Shortness of Breath
- ❒ Recent Falls/Blackouts
- ❒ Asthma
- ❒ Unexplained Weight Loss
- ❒ Bronchitis
- ❒ Groin Numbness/Tingling
- ❒ Other Respiratory Condition
- ❒ Bowel & Bladder Difficulties
- ❒ Hearing Impairment
- ❒ Headaches
- ❒ Pregnancy
- ❒ Blood Diseases
- ❒ Metal Implants (incl. IUD)
- ❒ Other:

Past Surgeries or Injuries: (please list with dates)

_____
_____
_____
_____
_____

Injections: (please list with dates)

_____
_____

- Is there anything else we should know about your health? _____
_____
_____

- Do you have a return appointment with the doctor who referred you? □ YES □ NO
If yes, when? _____

- What do you expect/hope to achieve from therapy? _____
_____

- Are you presently receiving or have you ever received any of the following treatment for your current problem?

□ Chiropractic □ Massage □ Occupational Therapy □ Naturopathic

□ Reflexology □ Acupuncture □ Physiotherapy □ Podiatry

NOVA PHYSIOTHERAPY

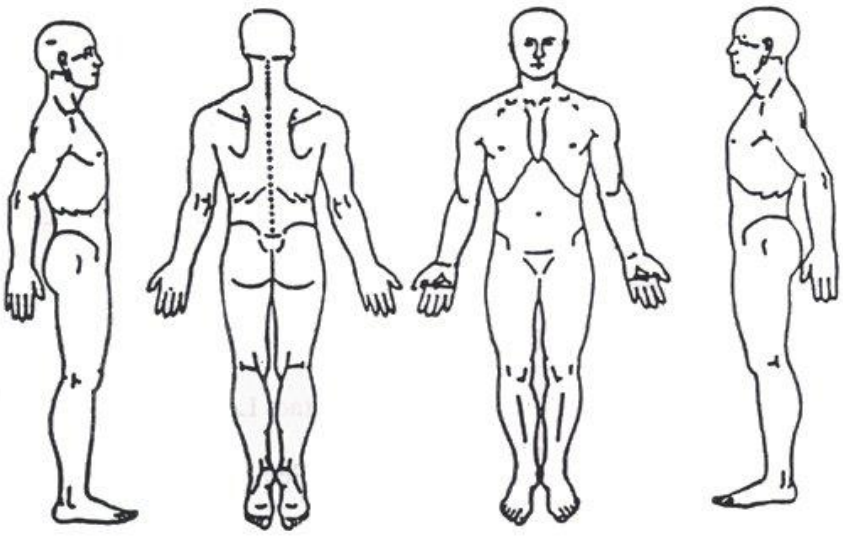
Please list any medications you are currently taking:

MEDICATION	DOSE	HOW OFTEN

Have you had any of the following tests for the condition for which you are presently referred?

TEST	YES	NO	WHEN	LOCATION OF TEST	RESULTS
X-rays					
CT Scan					
EMG/nerve conduction					
MRI					
Bone Density Study					
Ultrasound					
Other (specify)					

Please indicate any areas which you presently suffer pain or discomfort by shading in that area on the diagram:



Consent to Treatment:

- ❒ Physiotherapy
- ❒ Massage Therapy
- ❒ Chiropractic
- ❒ Dietitian

Signature:_____

Date:_____