INTAKE FORM

NAME:____
(Last) (First) (Middle initial)

ALBERTA PERSONAL HEALTH NUMBER: ___ ___ ___ ___ ___ - ___ ___ ___ ___

DATE OF BIRTH: ______/__________/__________ **AGE:**_______ **PRONOUNS:**_____________________
Day / MM / Year

ADDRESS: ____

____
(City) (Province) (Postal code)

TELEPHONE: HOME ______________________________ **WORK/CELL** ____________________________________

E-MAIL:____
Please indicate your interest in the following services:

☐**I would like email reminders of my appointments** ☐**I am interested in receiving a clinic newsletter (quarterly)**

Please initial here indicating you have read the Missed Appointment and Respecting Your Privacy Documents __________

Referring Physicians Name (if applicable):____

Emergency Contact Person:____Phone:______________________________

Have you had physical therapy for this body part? No______Yes_____Clinic:__________________Date:____________________

Did you have surgery for this injury or fracture a bone? No___Yes____Doctor________________When:___________________

If a fracture, when was the cast removed? ____

Is this a Workers' Compensation Case? No______Yes______WCB CLAIM #________________________________

Was this injury a result of a Motor Vehicle Collision? No______Yes_______If so, please provide the following:

Date of Accident: _____________________Insurance Company:________________________________

Adjustor's Name:______________________Adjuster's Phone #________________________AB Forms Completed:________

Do you have any of the following?

Heart Disease___________Metal Implant______High Blood Pressure____Diabetes______Pace Maker__________
Drug Allergies:____Other:____

- Patients and clients are required to pay privately, as per the posted fee schedule.
- My signature below acknowledges my understanding of my liability for any costs incurred by me at this office. Payment options include Debit, Visa, Mastercard, electronic transfer, cash, or cheque.
- My signature below also permits disclosure of information relating to my attendances to Extended Health Benefit Providers for the purposes of confirming my attendance and the nature of my submitted claim.
- If you have any questions throughout the course of your physiotherapy sessions, please do not hesitate to discuss them with your physiotherapist or Clinic personnel.

Conditions of Service
I understand I provide consent to assessment and the fees associated with that assessment.
I understand my personal information is being collected under the authority of the Health Information Act (HIA), the Personal Information Protection Act (PIPA), and the Personal Information Protection and Electonic Documents Act (PIPEDA).
I also understand the information collected about me during the assessment may be disclosed to my physician as part of the circle of medical care.

Signature_______________________________________ Date:____
If under 18 years must be signed by parent/guardian