GREATER TORONTO REHABILITATION CLINICS
PHYSIOTHERAPY, CHIROPRACTIC, FOOT CARE & SPORTS INJURY

Royal Physio Clinic ❑ Vaughan Clinic ❑ King West Club ❑ Home Care ❑

All information will be held in strict confidence.

Last Name______________________________ First Name________________________________ Initial______

Date of Birth (*dd/mm/yyyy*) ____/____/_______ Occupation________________________________

Address____ Postal Code____________________

Work Phone_______________________ Home Phone______________________ Cell Phone ____________________

Email ____

For WSIB Claims Only: OHIP No. ________________________ WSIB Claim No. ________________________

For Auto Insurance Claims Only:

Insurance Company__________________ Phone____________________ Address________________________________

Claim No. _________________________ Policy No. ________________ Date of Accident (*dd/mm/yyyy*) ____/____/____

Adjustor Name ___________________________ Adjustor Phone Number ______________________________

Family Physician

Name ___________________________________

Address _________________________________

Phone ___________________________________

Fax ____________________________________

How did you hear about us?

Doctor ____ Friend ____ Media ____ Walk-In ____

Insurance Co. ____ Family Member ___ Other ____

Referral Source's Name (*Optional*) _______________________

Contact in case of Emergency

Name __________________________________ Relationship _____________________________

Home Phone ____________________________ Work Phone _____________________________

Our cancellation policy requires 24 hours notice or you will be charged 100% of the fee

This signed form and photocopies of this signed form will serve as authorization to Greater Toronto Rehabilitation Clinics to obtain/release medical information pertaining to myself from/to my family physician and to other Greater Toronto Rehabilitation Clinics practitioners. It also serves as an agreement to provide payment to Greater Toronto Rehabilitation Clinics, at the time of each visit, and later claim through any extended health benefits plan, as appropriate. The undersigned has read and understands the cancellation policy.

Patient Signature: ____________________________________ **Date:** _____________________________________

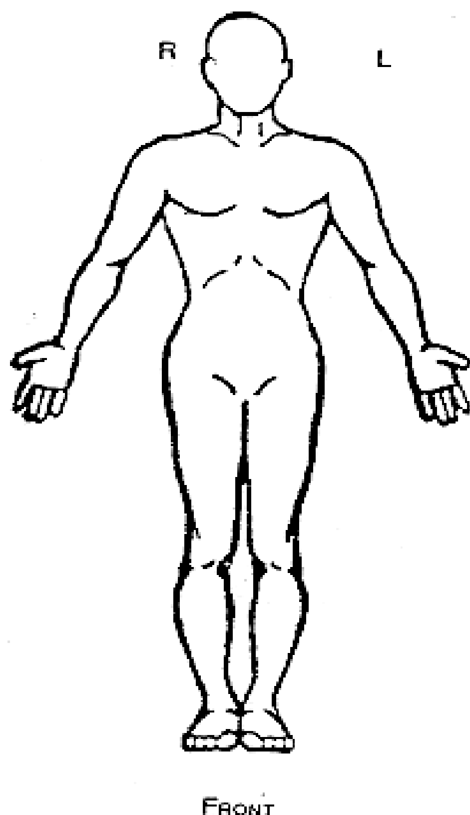
GREATER TORONTO REHABILITATION CLINICS
PHYSIOTHERAPY, CHIROPRACTIC,
FOOT CARE & SPORTS INJURY

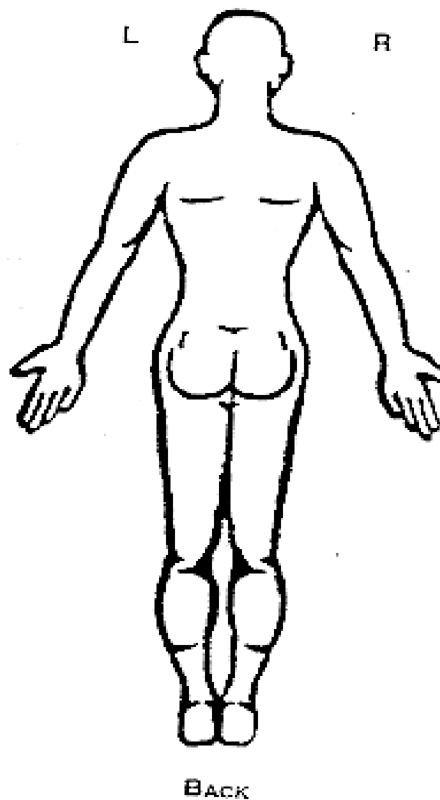
SYMPTOM DIAGRAM

In the diagrams provided below, please mark the areas on your body that you feel best represent the pain or sensation you are experiencing. Please include all areas. Use the symbols provided below.

Symbols

Numbness	===	Pins & Needles	:::::::
Burning	XXX	Stabbing & Sharp	//////
Dull & Aching	+++	Stiff & Tight	222





Patient's Name: ______________________________

Patient's Date of Birth: ______________________________

Date: ______________________________

GREATER TORONTO REHABILITATION CLINICS
PHYSIOTHERAPY, CHIROPRACTIC,
FOOT CARE & SPORTS INJURY

CONFIDENTIAL HEALTH PROFILE

Please complete by checking boxes that apply to you

Heart/Circulatory Conditions ❑

Dizziness/Fainting ❑

Muscle/Joints-Pain/Tension ❑
Neck ❑
Shoulders ❑
Elbows ❑
Back *(upper, mid, lower)* ❑
Hips ❑
Knees ❑
Other____________________ ❑

Rheumatoid Arthritis ❑

HIV/AIDS ❑

Skin Conditions/Bruising ❑

Digestive/Urogenital Conditions ❑

Breathing/Respiratory Conditions ❑

Diabetes ❑

Cancer ❑

For Women: Pregnant? ❑
Number of weeks_________
Due Date________________

Injury Affecting Sleep Yes ❑ No ❑

Blood Pressure High ❑ Low ❑

Accidents/Fractures/Surgeries
(Location & Date):

____

____

____

Medications *(List all)*:

____

____

____

Any other information your treating practitioner should be aware of?

____

____

____

Exercise Activity
(Type & Frequency)

____

____

____

Patient's Name: ______________________________

Patient's Date of Birth: ______________________________

Date: ______________________________

GREATER TORONTO REHABILITATION CLINICS

PHYSIOTHERAPY, CHIROPRACTIC,
FOOT CARE & SPORTS INJURY

CONSENT TO TREATMENT

I hereby consent to the assessment and treatment performed by the Practitioner named below.

I understand that treatment may include treatments for therapeutic, preventative, palliative, diagnostic, cosmetic, or other health related purposes.

I understand that I may rescind or amend this consent in writing.

I further understand that the clinical, psychological and any other information which is gathered during the course of my treatment is confidential, but may be shared with my insuring agents, third party payers and/or physician(s) upon request.

I have read the above consent, and I have had the opportunity to ask questions about its content. This consent will cover the rehabilitation assessment and entire course of treatment.

____
Patient's Name (*Please print*)

____
Practitioner's Name (*Please print*)

____
Signature of Patient

____
Patient's Date of Birth

____
Date Signed

Royal Physiotherapy Clinic
130 Adelaide Street West
Toronto, ON M5H 3P5
(416) 361-6142, x204

Vaughan Physiotherapy, Chiropractic, and Foot Care Clinic
Piazza Del Sole
200 Windflower Gate, Unit 700
Vaughan, ON L4L 9L3
(905) 264-0250, x3

The Health Centre at The King West Club
266 King Street West
Toronto, ON M5V 1H8
(416) 260-9911