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

Royal Physiotherapy Clinic ❑ Vaughan Rehabilitation Clinic ❑ Higher Ground Health Clubs ❑

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:** _____

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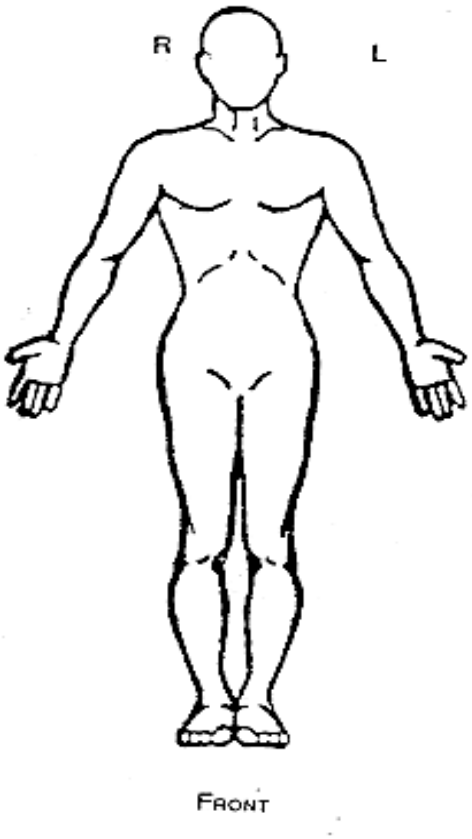
SYMPTOM DIAGRAM

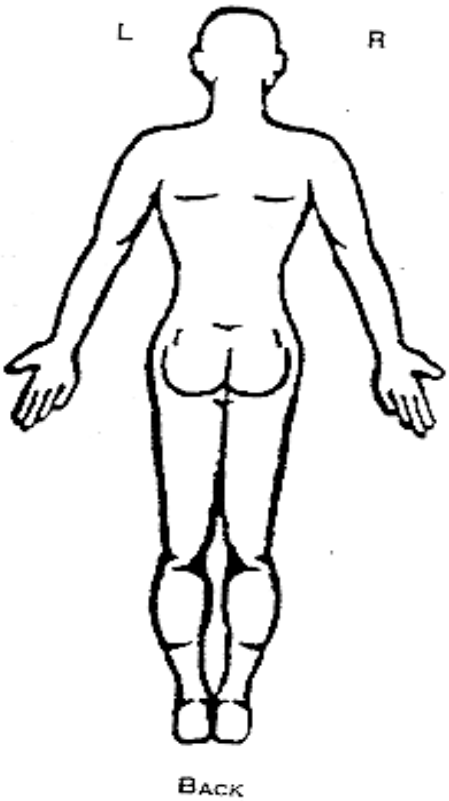
In the diagrams provided below, please mark the areas on your body that you feel best represent the pain or sensation you are experiencing. Please include all areas. Use the symbols provided below.

Symbols

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



FRONT



BACK

Patient's Name: _____

Patient's Date of Birth: _____

Date: _____

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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: _____

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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

HIgher Ground Health Clubs
382 Yonge Street
Toronto, ON M5B 1S9
(416) 913-9123, x2