ACTIVE LIFE
PHYSIOTHERAPY CENTRE
centre for quality care

Physiotherapy • Massage Therapy • Chiropractic • Acupuncture
Orthotics • Car Accident • W.S.I.B. • Sports Injury

(PLEASE PRINT)

Personal Information:

First Name: _____ Last Name: _____
Address: _____
City: _____ Postal Code: _____ Age: _____ Sex: _____
Date of Birth: _____ Spouse/Next of Kin's Name: _____
Home Phone no.: _____ Cell Phone no.: _____
Health Card no: _____ E-Mail Address: _____

Work Information:

Occupation: _____ Employer's Name: _____
Business/Work Phone no.: _____ Fax no.: _____

Extended Health Benefit (Coverage for Medical/Dental Expenses)

Subscriber/Employer Name: _____ Insurance Company: _____
Policy/Plan/Group no.: _____ Cert./ID/Employee no.: _____

Spouse/Guardians Health Benefit:

First Name: _____ Last Name: _____
Date of Birth: _____ Subscriber/Employer Name: _____
Insurance Company: _____
Policy/Plan/Group no.: _____ Cert./ID/Employee no.: _____

Medical Information:

Family Doctor: _____ Doctor's Phone no.: _____
Address: _____

Previous Treatment: (Please circle)

Physiotherapy	Massage Therapy	Orthotics
Acupuncture	Chiropractic	Others_____

Medical History:

History (Please circle appropriate answers to the following):

Diabetes:	Yes/No	Stroke	Yes/No
Thyroid Problem	Yes/No	Circulatory Disease	Yes/No
Angina/ Heart Attack	Yes/No	Cardiac Pacemaker	Yes/No
High Blood Pressure	Yes/No	Liver Disease	Yes/No
Cancer	Yes/No	Arthritis	Yes/No

Surgical Operations/Illness: _____

Authorization and informed consent

I hereby permit you to release to my Physician and/or Lawyer and/or any insurers all records, reports, progress notes, test result, opinion or other information, which you may possess, and for doing so this shall be your good and sufficient authority.

I hereby permit you to obtain record from my insurance company regarding payment of any invoice submitted by you, or any other pertinent treatment information you may need in reference to my physiotherapy treatment.

Physiotherapy Clients Only:
I give my consent to physiotherapy/rehabilitation treatment offered by Active Life Physiotherapy Centre at a Clinic setting. I understand that I can withdraw my consent to treatment at any time and understand that I can be seen by more than one physiotherapist if requested/needed.

The Physiotherapist has provided education about the benefits and side effects of physiotherapy treatment including K Tape and electrotherapeutic modalities, _____**Initials** _____

WSIB Injury: yes__ no__ Motor Vehicle Accident: yes__ no__

24 HOURS NOTICE REQUIRED CANCELLATION POLICY

There is a $25.00 cancellation fee billed directly to you for any missed appointments. Please inform us of any change in appointment time 24hrs prior. Third party sponsors do NOT cover this fee. (E.g. Private insurance, car insurance, WSIB)

We appreciate your consideration in this matter. **Patient's Signature** _____

_____ _____

Patient's Signature **Date**