# 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__

## 48 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 48hrs 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**