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PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name:	First Name and Initial(s):	Gender: ❑ M ❑ F	Date of Birth (yyyy-mm-dd):

Street Address:

City:	Province:	Postal Code:

Email:

By providing your email, you are consenting to email communication from Rebalance Sports Medicine such as appointment reminders, statements, invoices, exercise instructions & commercial electronic messages.

Health Card #:	Version Code:	Expiry Date (yyyy-mm-dd):

Phone (Home):	Phone (Work):	Phone (Mobile):

Please indicate the best method of contact during the day: ❑ Home ❑ Work ❑ Mobile

Emergency Contact (Name and Phone):

MEDICAL INFORMATION

Family Physician Name:	Physician Phone:

Physician Address:

HOW DID YOU HEAR ABOUT US?

❑ Website	❑ Street Signage	❑ Doctor's Referral	_____
❑ Google	❑ Return Patient	❑ Family/Friend Referral	_____
❑ Twitter	❑ Yelp	❑ Local Businesses	_____
❑ Facebook	❑ Yellow Pages	❑ Other	_____

(Rebalance Sports Medicine respects your privacy. We do not sell, rent, loan or transfer any personal information regarding our clients to any third parties.)

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CONFIDENTIAL HEALTH SCREENING QUESTIONNAIRE

(The health information requested on the following form will assist us in treating you safely. If you have any questions about the requested information, please feel free to ask.)

Primary reason for your visit?

Do you currently have or have previously had any of the following conditions?

❑ Diabetes	❑ Skin Conditions	❑ Gynecological Conditions	❑ Allergies
❑ Cancer	❑ Thyroid Problems	❑ Stroke/CVA	❑ Arthritis
❑ Hepatitis	❑ Lung Conditions	❑ Broken Bones	❑ Other
❑ HIV/AIDS	❑ Epilepsy	❑ Kidney Problems	_____
❑ Asthma	❑ Osteoporosis	❑ Heart Disease	_____

Current Medications:

_____
_____
_____

Drug Allergies:

_____
_____
_____

For Women:

1. Have you given birth?	❑ Yes	❑ No
2. Have you had a C-Section?	❑ Yes	❑ No
3. Are you currently Pregnant?	❑ Yes	❑ No

Have you had any surgeries? Please provide details.

Do you currently (or within the past year) have any of the following symptoms?

❑ Chest Pain	❑ Vomiting/Nausea	❑ Unexplained Weight Change
❑ Heart Palpitations	❑ Difficulty Swallowing	❑ Loss of Balance/Co-ordination
❑ Shortness of Breath	❑ Speech Disturbances	❑ Weakness in Arms and Legs
❑ Dizziness/Blackouts	❑ Fevers/Chills/Sweats	❑ Numbness in any part of your Body
❑ Loss of Appetite	❑ Unrelenting Night Pain	❑ Urinary/Bowel Problems

Please tell us what your three (3) primary goals are or what you wish to achieve at Rebalance?

1. _____
2. _____
3. _____

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INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

PLEASE READ CAREFULLY

I understand that assessment and treatment at Rebalance Sports Medicine may include, but is not limited to: exercise prescription, manual therapy techniques (such as mobilizations, manipulations, soft tissue release and stretches) and therapeutic modalities (such as heat, ice, electrical stimulation, ultrasound, laser and shock wave therapy). Other treatment options include acupuncture/dry needling that involves the insertion of disposable and sterile needles through the skin into targeted tissue structures.

It is the policy of Rebalance Sports Medicine to ensure each patient is educated about the benefits, side effects, and potential complications of each treatment option used by our therapists. I understand that the primary goals of my treatments are to help reduce my pain, improve my mobility, strength, endurance, my overall functioning and quality of life.

I understand that there are very small possibilities of risks or complications that may result from the above listed treatments. I do not expect the therapist to anticipate all the possible risks and complications. I rely on my therapists' judgment to make decisions based on my best interests.

POTENTIAL SMALL BUT POSSIBLE RISK FACTORS

Manual Therapy: Joint and/or muscle soreness
Exercise Therapy: Joint and/or muscle soreness
Electrical Modalities: Minor skin irritations such as redness or rash
Therapeutic Taping: Minor skin irritations such as redness or rash
Acupuncture/Dry Needling: Minor soreness, bleeding, bruising, nausea, fainting, headache, infection, possible perforation of internal organs and stimulation of labour in pregnant women

I will immediately notify my therapist of any changes in my pregnancy or medical status.

I will have the opportunity to discuss with my therapist, the nature and purpose of all my treatments and I accept the fact that there is no guarantee to the effectiveness of the treatment. I am aware that I may withdraw this consent and discontinue my treatment at any time.

I consent to the assessment and treatment offered to me by my therapist. I intend this consent to apply to all my present and future care at Rebalance Sports Medicine. I consent that the health records collected at Rebalance Sports Medicine will be available to all health providers involved in my circle of care. (*For more information about your health records please ask to view our Privacy Policy).*

_____	_____	_____
Patient/Guardian Signature	Patient Name (print)	Date
_____	_____	
Witness Signature	Witness Name (print)	

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PAYMENT AGREEMENT FORM

PAYMENT POLICY & INSURANCE COVERAGE

Therapy Services: Physiotherapy, Massage Therapy, Chiropractic, Acupuncture, Bracing and Orthotics are covered by most extended health care plans. Each plan can be variable with respect to amount covered per treatment and the annual limits. As the policy holder, it is **your responsibility** to contact your insurance company and determine the exact details of your coverage.

Medical Services: Sports Medicine consultations are covered by Ontario's Health Insurance Plan (OHIP). However, many administrative services and some medical procedures are deemed by OHIP to not be medically necessary and are therefore uninsured. It is Rebalance Sports Medicine's policy that these services are billable directly to the patient and payment is due on receipt of the service. Please refer to our "Uninsured Medical Services and Pricing List" for more details.

Payment for services is due in full by **Cash, Debit or Credit Card** at the end of each treatment session. A receipt with all of the required information will be provided to you so that you can submit it to your insurance company for re-imbursement. If you qualify for direct billing, you will only be required to pay any co-payments or deductibles not covered by your plan.

CANCELLATION POLICY

We require a **minimum of 24 hours notice** for change or cancellation of any appointment. This will allow us to fill the available time slot with another patient who needs our services. Your account will be charged the full treatment fee if you cancel with less than 24 hours notice or if you do not show up for your appointment.

Should you arrive late for your appointment or request to leave early, the full fee for the appointment time you have booked will also apply.

Please Note: We understand that your time is valuable and therefore make every effort to keep our schedule running on time. Due to the nature of our work, unexpected delays sometimes occur. Please be assured that under these circumstances you will still receive your full treatment time. Thank you for helping us to maintain a high level of service for all of our clients.

I fully understand the above and agree to abide by these policies:

_____ _____

Patient or Guardian/Parent Signature Date

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FEMALE SYMPTOM MONITOR FORM

PATIENT INFORMATION

Last Name:	First Name and Initial(s):
Date (yyyy-mm-dd):	
Occupation:	Date of Birth (yyyy-mm-dd):
Complaints: 1. 2. 3.	
When did this start?	

GYNECOLOGICAL INFORMATION

pregnancies: __ # live births __ Wt heaviest baby: __ lbs __ oz Length pushing stage: __ hours

Forceps? ❑ Yes ❑ No Episiotomies? ❑ Yes ❑ No Tears? ❑ Yes ❑ No C-section? ❑ Yes ❑ No

HRT? ❑ Yes ❑ No When? _____ Last Pap? _____ Normal? ❑ Yes ❑ No

Sexually active? ❑ Yes ❑ No Pain with sex? ❑ Yes ❑ No When? ❑ Penetration ❑ Thrusting

Birth control method: _____ C-Section? ❑ Yes ❑ No

Do you have trouble sleeping? ❑ Yes ❑ No If yes, ❑ trouble falling asleep ❑ trouble staying asleep

Do you have feelings of heaviness or pressure in your vagina? ❑ Yes ❑ No

Has anyone ever told you that you have a prolapse? ❑ Yes ❑ No

SURGICAL HISTORY

Abdominal: ❑ When? _____

Pelvic: ❑ When? _____

BLADDER SYMPTOMS

(please respond to the statements that best describe your symptoms)

I have experienced a leakage of urine with activities such as sneezing, running or laughing ❑ Yes ❑ No ❑ Sometimes

My leakage occurs after having a strong voiding sensation that feels uncontrollable ❑ daily ❑ weekly

How many times do you void during the day _____ # times/day

My bladder troubles cause me to go to the bathroom at night _____ # times/night

My bladder problems cause me to leak at night ❑ Yes ❑ No ❑ Sometimes

My incontinence requires me to wear pads _____ # pads/day

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When I void I don't empty completely and feel like I have to go again soon	❑ Yes ❑ No ❑ Sometimes
I have pain when I urinate	❑ Yes ❑ No ❑ Sometimes
I have to strain when I urinate	❑ Yes ❑ No ❑ Sometimes
I have leakage during intercourse	❑ Yes ❑ No ❑ Sometimes
I had problems with my bladder during my childhood	❑ Yes ❑ No
I feel overwhelmingly strong sensations prior to voiding but I don't leak	❑ Yes ❑ No
Fluid intake in 24 hours: #__ cups coffee/day #__cups water/day #__cups tea/day #__cups of other fluids/day	

BOWEL HISTORY

Frequency ___ / day

Fecal incontinence: ❑ Yes ❑ No

Fecal urgency: ❑ Yes ❑ No

Stool consistency: ❑ Loose ❑ Soft/formed ❑ Hard ❑ Varies

MEDICAL HISTORY

Urinary tract infections: ❑ Yes ❑ No Antibiotics recently? ❑ Yes ❑ No

Smoking: ❑ Yes ❑ No ___ # packs/day

Chronic cough: ❑ Yes ❑ No

Do you get blood in your urine: ❑ Yes ❑ No

Allergies (including latex):

Height: ___ ft. ___ in. Weight: ____ lbs BMI: _____ (therapist)

Back problems: ❑ Yes ❑ No

Neck Problems: ❑ Yes ❑ No Chronic: ❑ Yes ❑ No

Have you ever been treated for depression? ❑ Yes ❑ No

On a scale from 1-10, please rate your current pain/discomfort
(no pain) 1 2 3 4 5 6 7 8 9 10 (the most pain)

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PELVIC THERAPY CONSENT FORM

PLEASE READ CAREFULLY

Pelvic floor physical therapy assessment and treatment may include, and is not limited to, the examination of the pelvic floor musculature via an external and internal examination, through the vaginal and ano-rectal canals. This may occur during the initial assessment and may be required throughout subsequent treatments to address your specific condition.

The goals of treatment include but are not limited to:

- improving urinary or fecal incontinence
- addressing bowel and/or bladder dysfunction (frequency/urgency)
- addressing sexual health
- reduction of pelvic/low back/sacroiliac joint pain
- improving strength and endurance of the pelvic floor musculature
- improving overall function and quality of life

Risks and/or side effects associated with an internal examination of the pelvic floor musculature may include:

- Discomfort (pain, cramping, burning) in the pelvic/perineal area during/post examination
- Urge to void (urinate or defecate) during examination
- Vaginal or rectal bleeding post examination
- Small risk of infection post examination
- Unexpected emotional response
- Skin reaction to gloves or lubricant
- Nausea and/or light-headedness

Treatment may include:
Manual therapy of the pelvic floor, exercise, biofeedback, electrical stimulation and education regarding lifestyle.

I give permission for my pelvic physiotherapist to perform an external and internal examination of my pelvic floor for rehabilitation purposes. I understand the risks and benefits associated with this treatment.

I will immediately notify my therapist of any changes in my medical status.

I will discuss with my therapist the nature and purpose of all treatments prior to their administration.

I understand that I may withdraw my consent at any time and discontinue treatment at any time.

_____
Patient Name (print)

_____ _____
Signature Date