RYLANDER PHYSIOTHERAPY CENTRE

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Scarborough, Ontario M1B 5M5
Tel: 416-284-8973
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Patient Information

Please answer the following questions as accurately as possible.
The information provided will be helpful in creating treatment sessions that meet your specific needs.

Personal Information:

Name: _____ Date: _____

Address: _____ Date of Birth: _____

_____ Postal Code: _____

Telephone – Home: _____ Cell: _____ Work: _____

E-Mail Address: _____ Occupation: _____

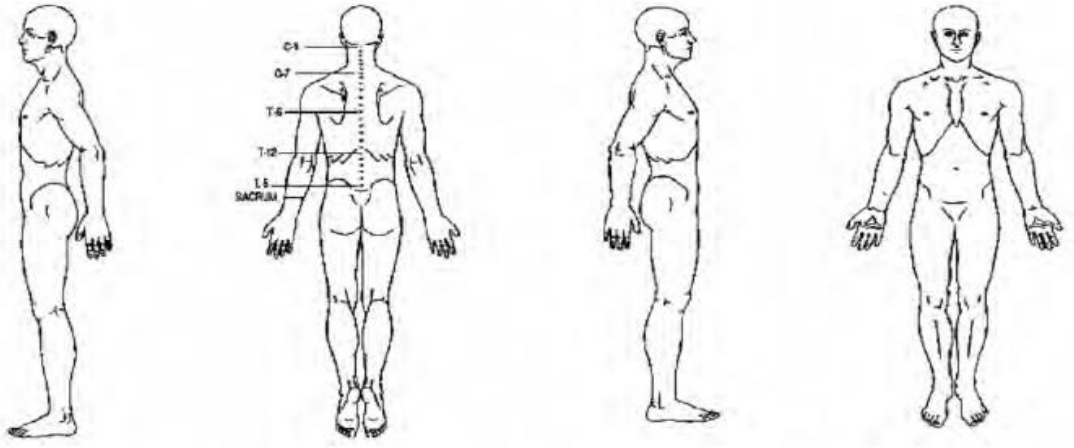
Next of Kin: _____ Telephone: _____

Please Circle:
Did the accident happen at work? Yes No
If yes, please sign our Workplace Safety Insurance Board Waiver Form.

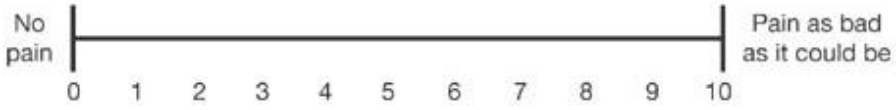
Was it a Motor Vehicle Accident? Yes No
If yes, and you are <u>not</u> claiming this accident with your Auto Insurance Company please sign our Motor Vehicle Accident Waiver Form.

How did you hear about us: Doctor Advertisement Friend Other

PLEASE INDICATE AREAS OF PAIN, TENSION AND/ OR DYSFUNCTION.
Draw or highlight to show where you feel pain or tension, have limited range of motion, or areas that create dysfunctional symptoms.



What is your pain scale?



Medical Information:

What is the primary complaint that brings you in for treatment today? _____

_____

Any secondary complaints you would like to address? _____

_____

Please describe any pain, limited range of motion or difficulty with activities due to your symptoms: _____

_____

How and when did these issues begin? _____

_____

Please list history of trauma (physical or emotional), accidents or surgery: _____

_____

What are your goals for therapy? _____

_____

Please check any of the conditions you've had in the past or currently have:

___ Cardiovascular Disease	___ Diabetes (Type 1 or 2)	___ Anxiety/Depression
___ Congestive Heart Failure	___ Thyroid Condition	___ Muscle/ Joint Pain
___ High/Low Blood Pressure	___ Chronic Infections	___ Sprains/ Strains
___ Blood Clots	___ HIV/AIDS	___ Tendonitis
___ Varicose Veins	___ Osteoporosis	___ Back or Neck Pain
___ Chest Pain/ Tightness	___ Arthritis (Ostero/Rheum)	___ Headaches/Migraines
___ Asthma/Difficulty Breathing	___ Kidney Disease	___ Tension/Stress
___ Sinus Problems	___ Digestive Problems	___ TMJ/Jaw Pain
___ Neurological Condition	___ Constipation/ Diarrhea	___ Earaches/Ring in Ears
___ Vertigo/Dizziness	___ Pregnancy	___ Eyestrain/ Irritation
___ Numbness/ Tingling	___ Menstrual Issues	___ Sleep Disorders
___ Multiple Sclerosis	___ Fibromyalgia	___ Rash/ Skin Conditions
___ Epilepy/ Seizures	___ Chronic Fatigue Syndrome	___ Allergies

Referring Doctor _____ Telephone Number _____

Family Doctor _____ Telephone Number _____

I CERTIFY, TO THE BEST OF MY KNOWLEDGE, THAT THE ABOVE INFORMATION IS COMPLETE AND TRUE. IF MY MEDICAL/ HEALTH STATUS SHOULD CHANGE, I WILL INFORM MY PHYSIOTHERAPIST OR MASSAGE THERAPIST IMMEDIATELY.

I give Rylander Physiotherapy Centre consent to carry out any physiotherapy/ massage therapy treatments that relate to my condition as well as the release of any information regarding my treatments and/ or progress (if requested) to my Insurance Company, Doctor, Rehab. or Worker etc…

I understand that Rylander Physiotherapy Centre has informed me in advance, of the cost of treatment(s), and agree to be personally responsible for full payment of all services rendered.

I understand I will be charged 100% of appointment cancelled or missed without two business days notice (Monday to Friday) of my scheduled appointment. I also understand that if I arrive late I will receive the remainder of the time scheduled, but will be liable for payment in full.

Patient Signature _____ Date _____

Signature of Parent or Guardian to treat a minor _____