New Patient Information

Last Name: ____________________________________ First Name: __________________________________

Date of Birth (YY/MM/DD): ______________________ Gender: ☐ Male ☐ Female

Address: ____

City: ___________________________ Province: ___________________ Postal Code: ________________

Home Phone: ____________________ Work Phone: ________________ Cell Phone: _________________

Email: ____

☐ I accept email reminders for my appointments

☐ I accept emails for promotions, updates, and other content

Primary Concern: _______________________________________ Occupation: ___________________________

OHIP Number: ____ Version Code: _________________________

Family Physician

Name: ______________________________________

Address: ____________________________________

City, Province: ______________________________

Phone: _____________________________________

Fax: _______________________________________

Last Visited: _______________________________

Do we have permission to contact your family physician? ☐ Yes ☐ No

How Did You Hear About Us?

☐ Family Doctor: _____________________________

☐ Other Referring Doctor: _____________________

☐ Team / Organization: ________________________

☐ Past Patient: _______________________________

☐ Web

☐ Social Media: ______________________________

☐ Print Advertising (Brochure, Signage, etc)

☐ Word of Mouth

Is this a result of a car accident? ☐ Yes ☐ No

Is this a result of a workplace accident? ☐ Yes ☐ No

Do you have extended health care benefits? ☐ Yes ☐ No

IF YES: Insurance Company name: _________________________________

Are you the policy holder? ☐ Yes ☐ No

IF NO: Policy Holders Last Name: ______________________ Policy Holders First Name: _______________________

Policy Holders Date of Birth (YY/MM/DD): __________________________

Policy #: ____________________ Member ID: ___________________

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New Patient Information

MEDICAL HISTORY - Indicate conditions you are experiencing or have experienced

Cardiovascular:

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chronic Congestive Heart Failure
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Palpitations
- ☐ Heart Murmur
- ☐ Stroke/CVA
- ☐ Aneurism
- ☐ Angina
- ☐ Blood Clots
- ☐ Raynaud's Disease
- ☐ Phlebitis / Varicose Veins
- ☐ Poor Circulation
- ☐ Pacemaker or Similar Device

Respiratory:

- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sinusitis
- ☐ Sinus Congestion

Do you smoke? ☐ Yes ☐ No

Blood:

- ☐ Anaemia
- ☐ Haemophilia
- ☐ Leukemia
- ☐ Hepatitis A B C

Gastrointestinal:

- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas/Bloating
- ☐ Nausea/Vomiting
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's/Colitis
- ☐ Hernia
- ☐ Ulcers
- ☐ Gall Bladder Problems
- ☐ Liver Problems
- ☐ Kidney Infections
- ☐ Bladder Infections
- ☐ Urination Problems
- ☐ Poor Appetite
- ☐ Excessive Thirst

Skin:

- ☐ Hypersensitivity
- ☐ Bruises Easily
- ☐ Rashes
- ☐ Eczema
- ☐ Psoriasis
- ☐ Athletes Foot
- ☐ Herpes
- ☐ Warts
- ☐ Skin Conditions:

Women:

- ☐ Pregnant
- ☐ Infertility
- ☐ Menstrual Concerns / Pain
- ☐ Menopausal Concerns
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Hysterectomy
- ☐ Vaginal Pain / Infection

Head / Neck:

- ☐ Headaches
- ☐ Migraines
- ☐ Whiplash
- ☐ Jaw Pain
- ☐ Ear Pain
- ☐ Hearing Problems
- ☐ Hearing Loss
- ☐ Vision Problems
- ☐ Vision Loss

Muscle / Joint:

- ☐ Muscle Sprain
- ☐ Ligament Sprain
- ☐ Spasms/Cramps
- ☐ Tendinitis
- ☐ Bursitis
- ☐ Fibromyalgia
- ☐ Ankylosing Spondylitis
- ☐ Arthritis OA RA
- ☐ Osteoporosis
- ☐ Herniated Disc
- ☐ Degenerative Discs
- ☐ Joint or Bone Disease
- ☐ Scoliosis
- ☐ Dislocation
- ☐ Fracture

Other Conditions:

- ☐ Diabetes
- ☐ HIV/AIDS
- ☐ Cancer; Type:
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Thyroid Disorders
- ☐ Lupus
- ☐ Loss of sensation; Where:
- ☐ Insomnia /Fatigue
- ☐ Fainting/Dizziness
- ☐ Anxiety/Nervousness
- ☐ Depression
- ☐ Alcohol/Drug Addition

See Over / Next Page →

New Patient Information

Please list all previous surgeries and dates:

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Please list all previous injuries and when sustained:

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Please list all medication you are currently taking:

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Patient Agreement

1. I understand that it is my responsibility to provide accurate and current information about my medical history.
2. I understand and acknowledge the fees for services rendered by any provider at Physio Sport Med of Oakville.
3. I understand it is my responsibility to cover the full cost of the treatment. If I have extended benefits I will pay on the days of service and seek reimbursement through the insurance company unless otherwise agreed. In the event that I am attending the clinic due to injuries sustained in a motor vehicle accident and the insurance is billed on my behalf, I will remit all payments received for services rendered to Physio Sport Med of Oakville.
4. I understand that I am responsible for tracking my insurance coverage. If my extended benefits reach maximum coverage, I will pay the difference to the clinic.
5. I acknowledge that all outstanding balances must be paid prior to my discharge from a treatment program.
6. I acknowledge the late cancellation and missed appointment policy. I agree to pay for the time blocked off for me should I not provide 24 or more hours notice.

Patient / Guardian's Name: ____

Signature: _________________________________ Date: ___________________________

Emergency Contact: ___________________________ Phone: __________________________