Physiotherapy - Confidential Patient Questionnaire

PERSONAL INFORMATION

Name:____ Date:_________________________

Address:____

City:__________________________________ Postal Code: __________________________

Birthdate: ______________________ Age:__________________

Phone #: Home:________________ Work:_________________ Cell :_________________

Email Address:____

Occupation:____

Do you have an open ICBC Claim?____

Emerency Contact:_____________ Relationship:____________Phone #:______________

Who may we thank for referring you to our office?:________________________________

CHIEF COMPLAINT

Please describe your chief health complaint: _______________________________________

How long have you had this condition: ____

Is it: *Becoming Worse* _______*Getting Better*________ *Constant* _______ *On/Off*_________

What makes it worse:____

Other Health Concerns:____

____

Please list any surgeries (with approximate dates)_________________________________

____

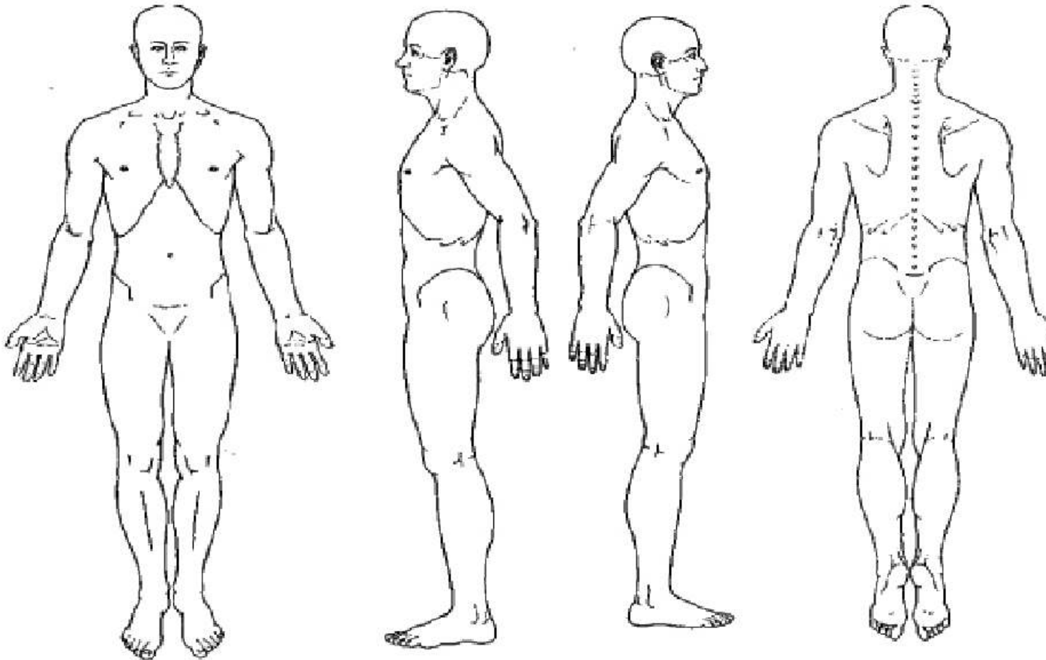
____

Are you taking medication? **YES** **NO** Please list all medications ________________________

____

____

Please Indicate Painful Areas:



Patient/Therapist Agreement:

PAYMENT IS DUE UPON SERVICE RENDERED.

Initial Assessment..........................$145.00

Your initial assessment will determine subsequent bookings and charges.

Subsequent Extended Visit $115.00 or Subsequent Visit $100.00

Initial___

It is our office policy to charge a fee equal to the visit fee if 24 hours notice is not given for the cancellation/missed of any appointment. We trust that you will document your appointment times. Please do not rely on office appointment reminders as this will not be considered for missed appointments.

I UNDERSTAND AND AGREE TO ABIDE BY THE ABOVE STATED POLICIES WITH THIS OFFICE. I ALSO UNDERSTAND THAT FEES ARE DUE WHEN SERVICE IS RENDERED, AND THAT I AM RESPONSIBLE FOR PAYMENT IN FULL AT THE TIME OF SERVICE.

_______________________________________ _________________________

Patient's Signature Date