OAKMONT PHYSIOTHERAPY CLINIC
www.OakmontPhysio.com
Unit #280, 809 West 41st Ave
Vancouver BC V5Z 2N6
Ph: 604-266-8894 | Fax: 604-266-7240

CONFIDENTIAL PATIENT INFORMATION -- Please print clearly

Last Name on Carecard:	First Name on CareCard:	Referred to as:	MI:

Street Address:	City and Province:	Postal Code:
Email:	**Care Card #:**	**Gender (please circle):**
		Male / Female
Date of Birth (dd/mm/yyyy):	**Primary phone #:**	**Alternate phone #:**

Family Physician and phone #:	Referring Physician and phone #:

Claim Type:

❒ WCB ❒ ICBC ❒ Personal ❒ MSP

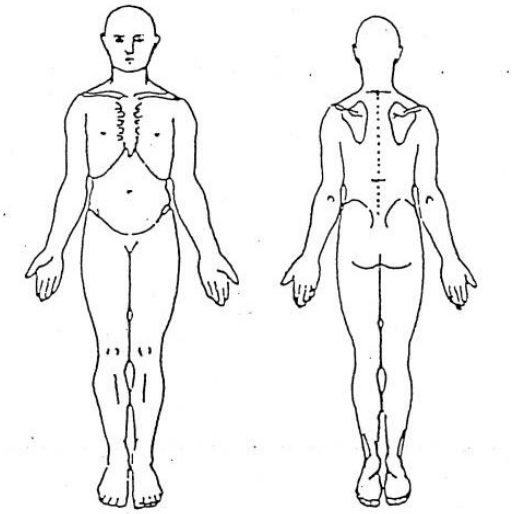
If WCB or ICBC:

Claim #:	Adjuster/Claim Manager Name:	Adjuster/Claim Manager Phone #:
Date of Injury (dd/mm/yyyy):	**Last Day Worked (dd/mm/yyyy):**	**Diagnosis:**

Medical History and Symptoms:

On the diagrams:

- Shade over the areas where you are experiencing symptoms.
- Indicate whether there is pain (P), tingling (T) or numbness (N) next to the shaded areas.
- Draw an arrow in the direction the pain radiates towards.



Other Symptoms (Check all that apply):

❒ Headaches
❒ Nausea
❒ Double Vision
❒ Fainting
❒ Dizzy/light headed
❒ Sleep disturbance
❒ Difficulty swallowing
❒ Difficulty speaking
❒ Other:

Medical History (please check off all that apply):

❒ Cancer
❒ Radio/Chemotherapy
❒ Hypertension
❒ Blood thinning medication
❒ Other (please describe):

❒ Cardiac Pacemaker
❒ Pregnant
❒ Stroke
❒ Other heart problems (past or present)

❒ Angina
❒ Steroids
❒ Diabetes
❒ Sudden weight loss/gain

❒ Osteoarthritis
❒ Osteoporosis
❒ Change in bowel function
❒ Past Surgery: _____
_____

Investigations (Have you had any of the following):			
❒ X-Ray	❒ CT Scan	❒ Arthroscopy	❒ EMG
❒ MRI	❒ US Scan	❒ ECG	❒ Other:

Medication (Please list all current):	Allergies:

Pain Behavior:			
My pain is	❒ Improving	❒ Worsening	❒ The same
My pain is	❒ Constant	❒ Intermittent	

What activities make your pain feel better?	
What activities make your pain feel worse?	

Pain Scale: How severe is your pain on average? (Circle one)

0 ---------- 1 ---------- 2 ---------- 3 ---------- 4 ---------- 5 ---------- 6 ---------- 7 ---------- 8 ---------- 9 ---------- 10

No Pain **Unbearable pain**

Patient Consent -- Please read carefully and check off each box

❒ **Informed Consent and Consent to Treatment**

I have been informed about my conditions at Oakmont Physiotherapy Clinic (referred to as the Clinic) and give voluntarily my consent to participate in the assessments and treatments outlined by the service provider. I understand this will involve my active participation and I will comply with the provider's recommendations in order to enhance my recovery. I acknowledge that my provider has provided me with information relating to my treatment, including possible side effects. Side effects include but are not limited to redness, bruising and soreness in treatment areas.

❒ If deemed beneficial to my condition by my therapist, I consent to dry needling treatments such as Acupuncture and/or Intramuscular Stimulation (IMS).

❒ **Authorization for Medical Records Release**

I authorize the Clinic and its associated therapists to communicate with my physician and/or any other pertinent party in order to obtain information, records, test results and any other documents related to my physical/mental condition including, but not limited to, all x-rays, medical reports, progress reports, reports of diagnostic tests/medical opinion as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

❒ **Consent to be contacted**

I give consent that I may be contacted at any of the phone numbers and/or addresses provided to the Clinic. Messages may be left at my contact number.

❒ **Consent for payment**

I agree that in the event I cannot attend my scheduled physiotherapy appointment(s), I will contact the Clinic at least 24 HOURS prior to my scheduled appointment. If I am unable to give appropriate notice of cancellation, I agree to pay **$50.00** as the missed or late physiotherapy fee. Treatment may be suspended until the amount has been paid in full.

Signature:	**Date:**

How did you find our clinic?
❒ Yellow Pages ❒ Existing patient ❒ Friend/Family ❒ Yelp ❒ Google ❒ Family Physician
❒ Referring Physician ❒ Facebook ❒ Physiotherapy Association of BC ❒ Other:_____