PARAGON PHYSIOTHERAPY

PATIENT INTAKE FORM

PATIENT INFORMATION:

<table>
<tr><td colspan="3">Name: Last / First / Middle</td><td>Mr. ☐ Miss. ☐
Mrs. ☐ Ms. ☐</td></tr>
<tr><td colspan="2">Address:</td><td>M ☐
F ☐</td><td>DOB:</td></tr>
<tr><td>City:</td><td>Province:</td><td colspan="2">Postal Code:</td></tr>
<tr><td>Home #:</td><td>Work #:</td><td colspan="2">Cell #:</td></tr>
<tr><td>Email:</td><td>Family Physician:</td><td colspan="2">Physician's Clinic:</td></tr>
<tr><td>Occupation:</td><td colspan="3">Employer:</td></tr>
<tr><td>Injury Date:</td><td colspan="3">MHIS#</td></tr>
</table>

EMERGENCY CONTACT:

Name:	Home:
Address:	Work:
Relationship:	Cell:

INSURANCE INFORMATION:

☐ MPI	Claim #:	Adjuster:
☐ WCB	Claim #:	Adjuster:
☐ Blue Cross	Contract #:	Group #:
☐ Other	Company Name:	Contract #:

Should, for any reason my insurance plan fail to pay for treatment or become exhausted, I assume responsibility for payment. I understand that accounts over 30 days will be subject to 2% monthly interest. I also understand the clinic's policy on cancellations and no shows: For cancellations with less than 24 hours notice, there will be a $25 cancellation fee. For missed appointments, without contact, you will be charged a full treatment fee: Assessment $64, Treatment $51.50 (fees are subject to change without notice).

Patient/Guardian Signature:____ Date:__________________

Should my physician or insurance plan request information regarding injuries sustained by me and the treatment rendered by this clinic, this shall be your full and sufficient authorization for so doing unless and until you are advised otherwise by me in writing.

Patient/Guardian Signature:____ Date:__________________

PARAGON
PHYSIOTHERAPY

Previous Medical History

Date:____________________

1: Past Surgeries:____

____

2: List all Medication:____

____

____

3: Natural/Herbal Remedies:____

4: Pregnant Y ☐ / N ☐ Past Pregnancies:____

5: Respiratory Problems:____

6: Smoker Y ☐ / N ☐ If yes, how many packs per day:____

7: Cardiac Problems:____

8: Rheumatoid Arthritis:____

9: History of Cancer:____

10: Osteoporosis / Osteopenia:____

11: Fibromyalgia:____

12: Bowel or Bladder Changes:____

13: Recent Weight Loss:____

14: Recreational Drugs:____

15: Night Pain:____

16: Night Sweats:____

17: Dizziness:____

18: Nausea:____

19: Headaches:____

20: Increased Pain with Cough/Sneeze:____

Is there any other information that would be important or helpful for the physiotherapist to know?

____

____

____ ____

Patient/Guardian Signature Physiotherapist Signature