NEW PATIENT INFORMATION

Carlisle Physiotherapy and Rehabilitation

Nature of Injury: _____

Last Name: _____

Date of Birth (YY/MM/DD): _____

Health Card Number: _____

Address: _____

City / Province: _____

Postal Code: _____

Occupation: _____

First Name: _____

Gender: ☐ Male ☐ Female

Home Phone: _____

Mobile Phone: _____

Business Phone: _____

Email: _____

☐ I accept email reminders for my appointments

FAMILY PHYSICIAN

Name: _____

Address: _____

City / Province: _____

Phone: _____

Fax: _____

Last Visited: _____

REFERRED BY

☐ Family Doctor: _____

☐ Other Referring Doctor: _____

☐ Team / Organization: _____

☐ Word of Mouth

☐ Web

☐ Advertising / Brochure

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 of Carlisle Physiotherapy and Rehabilitation.
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 Carlisle Physiotherapy and Rehabilitation.
4. I acknowledge that all outstanding balances must be paid prior to my discharge from a treatment program.
5. 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: _____

+ PLEASE FAX or EMAIL THIS FORM

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Carlisle Physiotherapy and Rehabilitation
16 William Street
Carlisle, ON L0R 1H2
T: (905) 690-9335
F: (905) 690-0789
Email: carlisle.physio@hotmail.ca

carlislephysiotherapy.ca

NEW PATIENT INFORMATION

Carlisle Physiotherapy and Rehabilitation

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

IF YES: Claim #: _____ Date of Accident: _____

Extended/Private Insurance Company: _____

Auto Insurance Company: _____

Adjuster Name: _____

Adjuster Phone: _____ Adjuster Fax: _____

IDENTIFY ANY CARDIOVASCULAR ISSUES

Blood Pressure (high/low) ☐Yes ☐No

Cholesterol (high/low) ☐Yes ☐No

Palpitations ☐Yes ☐No

History of heart disease or stroke ☐Yes ☐No

Pacemaker or similar device ☐Yes ☐No

IDENTIFY ANY PULMONARY ISSUES

Do you smoke? ☐Yes ☐No

If yes, for how long? _____

Asthma ☐Yes ☐No

History of bronchitis or pneumonia ☐Yes ☐No

IDENTIFY ANY OTHER MEDICAL ISSUES

Bleeding disorders (i.e. hemophilia, sickle cell, etc.) ☐Yes ☐No

Diabetes – Type I or Type II ☐Yes ☐No

Bowel or bladder problems ☐Yes ☐No

History of cancer ☐Yes ☐No

Currently pregnant or possibly pregnant ☐Yes ☐No

Headaches ☐Yes ☐No

Dizziness ☐Yes ☐No

Difficulty speaking ☐Yes ☐No

Double vision ☐Yes ☐No

Difficulty swallowing ☐Yes ☐No

Suddenly falling (i.e. legs giving out) ☐Yes ☐No

Previous surgeries ... if yes, please list ☐Yes ☐No

_____

_____

List previous injuries and when sustained:

_____

_____

List any medication you are currently taking:

_____

_____

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