Ascent Integrative Health
Physiotherapy Intake Form

Welcome to Ascent! We are honoured to partner in your health goals. To assist us in providing you with the best possible care, please fill out the following questionnaire accurately and thoroughly before your first appointment. All information is strictly confidential. *Contact Info: T: 403.262.1121 F: 403.262.1371 E: info@ascenthealth.ca*

Patient Information

Today's Date: _____ Gender: _____

Full Name: _____ Preferred Name: _____

Address: _____ Postal Code: _____ City: _____ Prov: _____

Home Phone: _____ Cell: _____ Work: _____

E-mail: _____ ☐ I would like to receive E-mails for appointment reminders, clinic information/ updates, promotional materials etc. *(please note you can opt-out at any time)*

Age: ____ Birthdate: (DD)____/ (MM)_____ / (YY)_____ Alberta Health Care Number _____

Marital Status: _____ Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone No: _____

Is this a WCB injury: ☐ No ☐Yes Are your injuries related to a Motor Vehicle Accident? ☐ No ☐ Yes

Name and contact of adjustor: _____ Claim #: _____

Date of accident: _____

Medical Information

Family Medical Doctor's Name: _____ Clinic: _____

Date of Last MD Visit: _____ Reason: _____

What therapy have you previously received? ☐ Chiropractic ☐ Massage ☐ Acupuncture ☐ Physiotherapy

*Communication between healthcare providers can greatly improve the quality and safety of patient care.
If necessary, do you consent to allow your health provider at Ascent to contact your medical doctor? ☐ No ☐ Yes

Extended Health Benefits

Do you have a private insurance plan? ☐ No ☐Yes (Self) ☐Yes (Spouse) _____

We are able to direct bill for most group benefit companies.

Name of benefit provider: _____

Policy No: _____ Member ID: _____ Group No: (*ABC Only): _____

How Did You Find Us?

☐ Referred by Friend/Family ☐ Referred by Medical Doctor ☐ Internet/Website ☐ Walk by

☐ Other: _____ Whom may we thank for this referral? _____

Purpose of Visit?

What is your main health concern or complaint? _____

When did your symptoms first begin? _____

Have you had this before? ☐ No ☐ Yes ; Who did you see for treatment? _____

Is it getting: ☐ Worse ☐ Better ☐ Not Changing

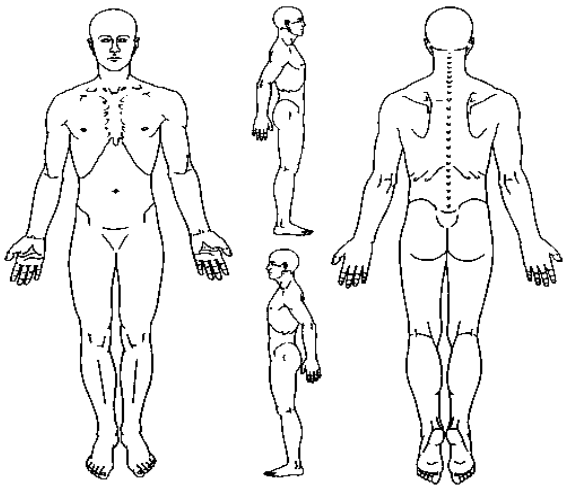
What do you hope to gain from your treatment here?

☐ **Resolve Pain:** Get me moving pain-free

☐ **Optimize Recovery:** Get me moving pain-free and provide guidance and rehabilitation to restore normal function

☐ **Improve Overall Health:** Get me moving pain-free, provide guidance and rehabilitation to restore normal function and help me be proactive in my health and wellness

On the diagram(s) below, please circle the area(s) that applies most to where you experience symptoms or feel pain.



Use these letters to describe the pain:

S sharp **D** dull **A** achy **H** hot **C** cold **N** numb/tingling **DB** deep and boring **V** variable

Please notes that this diagram cannot be filled out on the computer. Please complete once you've printed the form.

Please rate your pain LEAST to WORST (Least -0, Worst - 10: _____

When do you feel the pain? ☐ Constantly ☐ Intermittently ☐ At Night ☐ In the Morning

Does the pain radiate down your legs or arms? ☐ No ☐ Yes

What activities are you having problems with?

☐ Balance ☐ Gripping ☐ Lifting ☐ Reaching ☐ Standing

☐ Bending ☐ Housework ☐ Pulling ☐ Sitting ☐ Travelling

☐ Fatigue ☐ Kneeling ☐ Pushing ☐ Sleeping ☐ Walking ☐ Other_____

What relieves your pain?

☐ Rest ☐ Ice ☐ Massage ☐ Other: _____

☐ Movement ☐ Heat ☐ Medication: _____

Have you seen anyone else for this condition? ☐ No ☐ Yes: Who have you seen?_____

Have you had any imaging for this condition: ☐ X-Ray ☐ CT ☐ MRI ☐ Ultrasound Date: _____

Does this problem interfere with: ☐ Work ☐ Family & Social Life ☐ Sports & Hobbies ☐ Sleep

Do you have any secondary complaints? _____

_____

Health History

Please list any serious illnesses, injuries or surgeries and when they occurred: _____

_____

Please list any medication you have taken in the past 6 months: _____

_____

Are you currently pregnant or have recently been pregant? _____

_____

Cancellation Policy & Fee Schedule

I realize that my health insurance may not cover 100% of the recognized fee schedule and that I am responsible for any incurred appointment fees. A **minimum of 24 hours notice** is required for appointment changes and/or cancellations. If less than adequate notice is provided, or if you miss your appointment, Ascent reserves the right to charge your account the full amount of the scheduled appointment.

☐ I agree to the terms ☐ I do not agree to the terms Signature: _____

Confidentiality & Disclosure of Personal Information

Ascent Integrative Health (ASCENT) understands the importance of protecting personal information. We are committed to the collection, use, and disclosure of this information in a responsible way. Staff members who come into contact with your personal information are trained in the appropriate use and protection of your information.

By signing the consent section of this form, you agree to give consent to the collection use, and disclosure of your personal information for the purposes of:

- Delivering safe & effective patient care
- Enabling us to contact you & process payments
- Communicating with other healthcare providers
- Completing & submitting claims on your behalf to third party payers
- Complying with legal and regulatory requirements
- Filling out relevant requisition forms
- Complying with legal and regulatory requirements

I agree that ASCENT can collect, use, and disclose my personal information as set out above in the clinic's privacy code.

Signature: _____ Printed Name: _____

Informed Consent to Physiotherapy Treatment

During your physiotherapy visit, it is often necessary to expose and touch the area in need of treatment. Every effort is made to preserve modesty and keep you comfortable. Please communicate to your therapist if you have any concerns during the treatment.

Where appropriate, your treatment may include manual therapy, modalities (e.g. heat, ice, ultrasound, TENS, laser), and active exercise.

Please sign below to acknowledge your consent to treatment and your understanding of the liability of any costs incurred by you at Ascent Integrative Health.

I understand that it is my right to be a partner in my treatment program and that it is my responsibility to inform the therapist of any discomfort that I may experience during the course of treatment. I understand that the therapist will only provide treatments that the therapist is qualified to provide and that it is the responsibility of the therapist to inform me of any risks that may or may not be associated with the treatments that I receive; including but not limited to Manipulations, Exercise Rehabilitation and Soft Tissue Therapy. I know that I have the right to refuse any treatments and or techniques recommended by the therapist.

I consent to the physiotherapy treatments offered or recommended to me by my physiotherapist and intend this consent to apply to all my present and future physiotherapy care.

Dated this_____day of_____, 20_____

Patient Signature: _____ Printed Name: _____

Witness Signature: _____ Printed Name: _____

If the patient is under 16 years of age, the patient's parent or legal guardian must sign this form.

Witness Signature: _____ Date: _____