TELMA GRANT P.T.
Physiotherapy ROCKS!
234 King Street East, Unit 1
Bowmanville, ON L1C 1P5
O: 905-697-8001 F: 1-855-420-5774
TelmaGrant.Ca

# Health Questionnaire & Intake Forms

| **eMail: This is our primary way to send you appointment reminders. *Please be very neat.*** | | | Date |
|---|---|---|---|
| First Name | Middle Name | Last Name | Date of Birth (YYYY/MM/DD) |
| Home Phone | Mobile (Text #) | Work Phone | |

**Please provide an eMail address above. EMail is our primary way to send you reminders of your appointments.**
In addition to eMail, or if you do not have an eMail address, how would you like us to send you appointment reminders?
Please check at least 1 option.

☐ by Home Phone ☐ By text message ☐ By work phone ☐ By carrier pigeon

Address: _____ City _____ Province _____ Postal Code _____

☐ Presently working ☐ Not presently working

How did you hear about us? ☐ Doctor ☐ Family ☐ Friend
☐ Our website (TelmaGrant.Ca) ☐ Our sign Other:

## Cancellation Policy

**Please read carefully**

**Patient's / Guardian's initials**
X _____

We strive to be on time. If you are late for your appointment, we will accommodate you if we can without inconveniencing other patients, but if we cannot, we will reschedule your appointment.

To cancel an appointment, please give us at least 24 hours' notice before your appointment time. You can contact us by phone or email.

Patients who do not provide 24-hours' notice, or who miss an appointment may be charged a $10.00 Cancellation / Missed Appointment Fee.

Cancellation / Missed Appointment fees are not covered by insurance or OHIP.

If you miss your initial assessment you may be placed on Same Day Scheduling which would not allow you to book appointments in advance.

After cancelling (with less than 24 hours' notice) or missing 2 appointments, you may be placed on Same Day Scheduling

WSIB and MVA insurers expect regular attendance to physiotherapy as part of an approved treatment plan. Poor attendance can affect the status of your claim.

## Payment Policy

Payment is due at the end of every appointment.
**Please note:** Clients must keep track of their own insurance coverage limits & are responsible for any charges not covered by insurance. Telma Grant, P.T. is not responsible for tracking coverage limits.

I _____ (name of patient, parent or guardian) hereby authorize Telma Grant, P.T. to release reports and / or all or part of my (or my child's) physiotherapy patient record to the following:

☐ My Family Physician Dr: _____ ☐ My Specialist Dr. _____

☐ Other. Please specify: _____

Date
(YYYY-MM-DD) _____ _____
Signature

**Health Information Custodian (HIC):** Telma Grant, P.T. acts as the HIC for her clinic. Your personal and health information are kept confidential in accordance with our Privacy Policy. If necessary, you may access your information by contacting Telma Grant, P.T.
We charge $100.00 to provide a copy of a patient's clinical record.

**First Name** **Middle Name** **Last Name** **DOB (yyyy-mm-dd)**

Date (yyyy-mm-dd)

◯ I am left handed ◯ I am right handed

| **Medical history: Please check any conditions you have a history of.** | | | |
|---|---|---|---|
| ☐ abnormal bleeding | ☐ latex allergy | ☐ chronic heartburn | ☐ auto immune disorder |
| ☐ pacemaker | ☐ heart palpitations | ☐ history of ulcers | ☐ osteoporosis |
| ☐ seizures / epilepsy | ☐ hearing problems | ☐ shortness of breath | ☐ chronic lung problem |
| ☐ bowel or bladder problems | ☐ heart problems | ☐ arthritis | ☐ abnormal heart rate |
| ☐ diabetes | ☐ asthma | ☐ dizziness | ☐ night sweats |
| ☐ high blood pressure | ☐ emphysema | ☐ angina (chest pain) | ☐ high cholesterol |
| ☐ allergic to skin tape / band aids | ☐ intestinal upset | ☐ | ☐ |
| ☐ cancer / tumors: Where _____ | ☐ thyroid problem (hyper or hypo) | ☐ pregnant or suspect pregnancy? | ☐ recent and sudden weight loss / gain |

| | | | | |
|---|---|---|---|---|
| Do you have a history of fractures? | ☐ **Yes** | ☐ **No** | Where? | |
| Do you have any metal implants? | ☐ **Yes** | ☐ No | Where? | |
| Do you smoke? | ☐ **Yes** | ☐ No | How much per day? | |
| Do you exercise regularly? | ☐ **Yes** | ☐ No | How often? | |
| Do you have any known allergies? | ☐ **Yes** | ☐ No | Please list | |

| **Medications: Please check if you are taking any of the following:** | | | |
|---|---|---|---|
| ☐ anticoagulants (blood thinners) | ☐ pain patch | ☐ OxyContin | ☐ muscle relaxants |
| ☐ steroids (cortisone) | ☐ Morphine | ☐ heart medication | ☐ anti inflammatories |
| ☐ diabetes medication (insulin) | ☐ Percocet | ☐ blood pressure medication | ☐ pain killers |
| Other | | | |

| | | |
|---|---|---|
| Are any of these medications to treat the current problem that brings you in for physiotherapy? | ☐ Yes | ☐ No |
| Does the medication help you with this current problem? | ☐ Yes | ☐ No |

| **Symptoms: In regards to your current problem?** | | | | | |
|---|---|---|---|---|---|
| Do you have any "pins and needles" or numbness in your extremities? | ☐ Yes | ☐ No | Do you have any weakness in your arms or legs? | ☐ Yes | ☐ No |
| Do you have any coordination or balance problems? | ☐ Yes | ☐ No | Do you have difficulty walking? | ☐ Yes | ☐ No |
| Do you experience dizziness or vertigo with a change in position? | ☐ Yes | ☐ No | Have you experienced headaches as a result of your condition? | ☐ Yes | ☐ No |
| Have you had this problem before? | ☐ Yes | ☐ No | | | |

| **Fall Checklist** | | | | | |
|---|---|---|---|---|---|
| Have you had a fall in the past 12 months? If yes, how many | ☐ Yes | ☐ No | If you have fallen, how many times in the last 12 months? | | |
| Have you ever had a fall that resulted in a broken bone? | ☐ Yes | ☐ No | Do you have a problem with your balance? | ☐ Yes | ☐ No |
| Do you have a problem with your vision? | ☐ Yes | ☐ No | Do you get dizzy when you stand up quickly? | ☐ Yes | ☐ No |
| Do you have a problem with your memory? | ☐ Yes | ☐ No | Are you afraid that you might fall again? | ☐ Yes | ☐ No |
| **Osteoporosis / Osteopenia** | | | | | |
| Have you been diagnosed with osteoporosis? | ☐ Yes | ☐ No | Have you had a bone density scan? | ☐ Yes | ☐ No |
| Have you been diagnosed with osteopenia? | ☐ Yes | ☐ No | If you have had a bone density scan, what is your DEXA T-Score? | | |

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# OHIP Consent to Release Personal Information

## For OHIP Patients ONLY

Telma Grant, P.T. is requesting your consent to release to the Ministry of Health and Long Term Care (the "ministry"), the information you provide on this form, as well as information about the physiotherapy service(s) you receive from the physiotherapy providers at Telma Grant, P.T. as of the date of your signature.

The ministry requires this information to verify that the services were provided to you as a patient of Telma Grant, P.T., and to pay Telma Grant, P.T. for providing the services.

If you choose not to consent to the release of this information, the ministry will not pay for the services that you receive, and you will be required to pay Telma Grant, P.T. directly for the services.

**Your consent will end when:**

1. You withdraw your consent by advising Telma Grant, P.T. at the telephone number or address above
2. You no longer qualify for Ontario Health Insurance Plan (OHIP)
3. You cease to be a patient of the physiotherapy providers at Telma Grant, P.T.

**If you have questions about this consent form please contact Telma Grant, P.T. at the above address.**

**I consent to Telma Grant, P.T. releasing the following information to the Ministry of Health and Long-Term Care ("ministry") as of the date indicated below:**

| First Name | Middle Name | Last Name | DOB (yyyy-mm-dd) |
|---|---|---|---|
| | | | |

| Ontario (OHIP) Health Card no. | Version Code | Expiry Date (yyyy-mm-dd) |
|---|---|---|
| | | |

If you were **admitted overnight** in a hospital, **for the same reason you need physiotherapy,** please give the hospital name: _____

Please give the hospital admission date (yyyy.mm.dd): _____

**ODSP / OW Patients ONLY**
**(Ontario Disability Support Program / Ontario Works)**

**Ontario Drug Benefit #** _____

**A description of the physiotherapy service(s) provided to me by physiotherapy providers at my physiotherapy clinic as of the date indicated below, and**

**The date(s) on which these service(s) are provided to me.**

**I understand that I can withdraw my consent by contacting Telma Grant, P.T. at the above and that if I withdraw my consent I will be required to pay the Telma Grant, P.T. directly for services that the clinic provides to me as a patient following the withdrawal of consent.**

**Patient Signature**

- ☐ I am signing on my behalf
- ☐ I am signing as a parent, or person who is lawfully entitled to give or refuse consent, on behalf of a child who is under 16
- ☐ I am signing as the guardian of the person, or attorney for personal care of an incapable adult

Name (please print) _____ Date (YYYY-MM-DD) _____ _____
Signature

Please provide your contact telephone number if you are signing on behalf of a child, or an incapable adult: _____