mariposa
Physiotherapy & Rehabilitation

8 Westmount Drive South
Orillia, ON., L3V 6C9
P: 705-327-0008
F: 705-327-0018
E: info@mariposaphysio.ca

PERSONAL INFORMATION

Name: _____ D.O.B.: _____ Gender: _____

Mailing Street Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Family Physician: _____ Specialist: _____

Emergency contact: _____ Phone number: _____

How did you hear about us or find us: _____

Parent or Guardian: if patient is under the age of 18 or incapable of making informed consent

Name: _____ Phone: _____

Address: _____

How will you be paying for your appointments:

☐ I will be responsible for and will be paying my own account: check here even if you have extended health insurance. Please call the clinic with your insurance information and request direct billing if applicable, this does require an additional consent form. We will send this to you by email and you can scan or fax it back to us.

☐ This is a Workplace Safety and Insurance Board Claim: Ensure you add WSIB & Employer to the consent form

Claim #: _____ Date of Injury: _____ Area of Injury: _____

☐ This is a Motor Vehicle Accident Claim: Ensure you add your insurance Co. name to the consent form

Insurance Co name:_____ Date of Accident: _____ Policy/Claim #: _____

Do you have extended health insurance in addition to your motor vehicle coverage? Yes □ No □

☐ Payments have been pre-arranged through a third-party payer

i.e. DVA, or other special pre-arrangement already discussed and pre-approved prior to your appointment

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CONFIDENTIAL HEALTH INFORMATION FORM

Please Rate your current pain level. Give your lowest to highest pain rating over the last 48 hours; where zero (0) = no pain at all to Ten (10) = emergency pain. _____/10 to _____/10

List 3-5 activities/actions that you are currently limited in or unable to perform, with respect to this condition. Then rate your ability to perform each activity from 0 (unable to do or participate at all) to 10 (full pre-injury abilities).

1. _____ ____/10
2. _____ ____/10
3. _____ ____/10
4. _____ ____/10
5. _____ ____/10

Are you currently working? Full time □ Part time □ Modified work □ Not at all □

What is your profession? _____ What are your normal hours: _____

Have you sought out legal council associated with this injury/condition? Yes □ No □

Are you currently experiencing or have a personal history of any of the following (check all that apply):

- □ Recent throat or chest infection
- □ Bowel of Bladder Problems
- □ Numbness in the legs/arms/groin
- □ Osteoporosis/Osteopenia
- □ Unexpected weight loss
- □ Allergies: _____
- □ Asthma
- □ Hemophilia
- □ Osteoarthritis
- □ Long term Steroid use
- □ Balance deficits
- □ Have a pacemaker?
- □ Currently Pregnant: How many months? _____
- □ Pain with Deep breath/cough/sneeze
- □ High Blood Pressure
- □ Hepatitis A, B or C
- □ Long term anticoagulant use
- □ Headache/Dizziness/Double Vision
- □ Cancer Type: _____
- □ MRSA
- □ Night pain
- □ Rheumatoid Arthritis
- □ Hepatitis
- □ Diabetes Type: _____
- □ Have metal in your body? Where: _____
- □ Other: _____

List your current medications: _____

_____

Have you had any surgeries? List & date: _____

Have you had imaging for this problem? What type and what were the results?

_____

Name: _____ D.O.B.: _____ Date: _____