Woodbridge Avenue Chiropractic and Wellness Centre
53 Woodbridge Avenue, Unit 4
Woodbridge, ON, L4L 9K9
P: 905-264-8107 F: 905-264-8542

Patient Information **Date:**

First Name			Last name			Gender □ M □ F
Address			Apt	City	Prov	Postal Code
Home phone	Cell phone		Date of birth (DD/MM/YYYY)			
Email Address					Occupation	
Marital Status: □ Married □ Single □ Divorced □ Other						
Emergency Contact: Name			Telephone		Relationship	
Family Doctor: Name					Telephone	
How did you hear about us?						

Health Information

Please list your medical conditions:	Medications:	Allergies: ________________.
______________	______________	________________.
______________	______________	Alcohol: □Yes □ No
______________	______________	Smoking: □Yes □ No
______________	______________	Regular exercise: □Yes □No
______________	______________	Hours of sleep /night: ____________.
______________	______________	Are you pregnant? □Yes □No
______________	______________	Due date:__________.

Previous surgeries and year:

Accidents/Injuries/Fractures:
- ▫Type ______________ Year ______________ Area of Injury ______________.
- ▫Type ______________ Year ______________ Area of Injury ______________.
- ▫Type ______________ Year ______________ Area of Injury ______________.

Please check if you have any of the following conditions or any of the following symptoms regularly

□ loss of consciousness □ dizziness □ numbness/tingling □ weakness □ frequent headaches □ vision change □ choking/trouble swallowing □seizures □ history of stroke □ hearing loss
□ shortness of breath □asthma □bronchitis □ emphysema
□ chest pain □atherosclerosis/vascular disease □history of heart attack □ aneurysm □ diabetes □high blood pressure □high cholesterol
□ loss of bowel/bladder function (□stool □urine) □prostate problems □kidney stones □ difficulty with urination (difficulty starting stream, burning, blood in urine)
□ abdominal pain □vomiting/diarrhea □gastric/duodenal ulcer □pancreas problems □ liver disease
□ osteoarthritis □rheumatoid arthritis □scoliosis □ ankylosing spondylitis □osteoporosis
□ recurrent fevers □ drenching night sweats □ weight loss
□ history of cancer - type:
□ skin conditions:
□ infections: □HIV □ tuberculosis □ herpes □ hepatitis
□ internal objects/devices: □ pacemaker □ metal/pins □ artificial joints □*Where?*
Women: □painful periods □excessive flow □cramping □hot flashes

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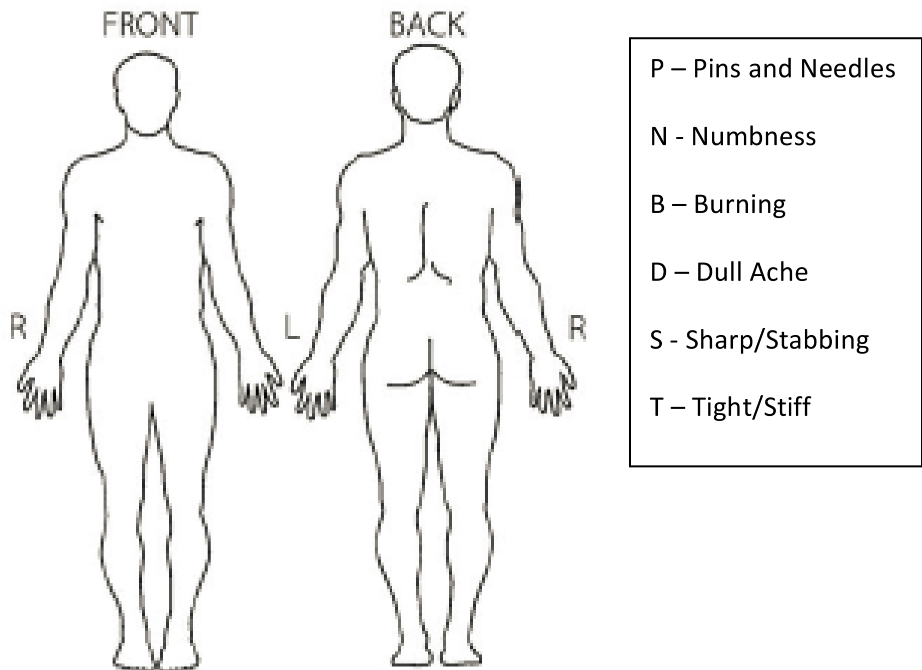
PLEASE CHECK IF THERE IS A FAMILY HISTORY OF THE FOLLOWING CONDITIONS AND SPECIFY FAMILY MEMBER	
□ osteoarthritis	□ rheumatoid arthritis
□ heart attack	□ cancer
□ stroke	□ diabetes
□ other	

PHYSIOTHERAPY INFORMATION
What is the reason for seeking care today:
Is this related to: □ Recent motor vehicle accident □ Work-related injury/accident (WSIB)
Have you had an xray for this problem? □Yes □ No When?
Have you seen another health care provider before for this condition? □Yes □No

PLEASE MARK ALL THE AREAS OF THE BODY WHICH YOU FEEL ARE PAINFUL OR PROBLEMATIC USING THE LETTER KEY BELOW:



PATIENT'S DECLARATION

All of the above health information is complete and correct to the best of my knowledge. I understand that omitting health information may be dangerous to my health.

Signature ___________________________ Date________________________.

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INFORMED CONSENT TO PHYSIOTHERAPY TREATMENT

I understand that the physiotherapist is providing physiotherapy services within their scope of practice as defined by the College of Physiotherapist of Ontario.

I have been told about the following:

- The diagnosis, and/or clinical impression, as known;
- Nature of treatment procedure(s) that is being suggested;
- Significant risks, benefits of treatment and reasonable alternative;
- Potential risks/consequences if treatment is refused/declined;
- Reasonable additional procedures which may be necessary, and;
- Remote risks, where the potential problems is serious;

I have carefully read and fully understand the above noted consent and I have had the opportunity to question the contents and my therapy and procedure(s) with the care provider. All of my questions have been adequately answered.

By signing this form, I confirm my consent and authorize Domenico Oppedisano, PT to form the treatment plan and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

____________________________	____________________________	____________________
(Signature of patient)	(Print name of patient)	Date
____________________________	____________________________	____________________
(Witness signature)	(Print name of witness)	Date