



2917 Lakeshore Blvd, West.
 Toronto, Ontario. M8V 1J3
 647-748-2917 | PHYSIOINTHESIX.COM

All information will be held in strict confidence.

Last Name _____ First Name _____ Initial _____
 Date of Birth (dd/mm/yyyy) ___/___/___ Occupation _____
 Address _____ City _____ Postal Code _____
 Email _____
 Home Phone _____ Work Phone _____ Cell Phone _____

Direct Billing Information: Insurance Company _____

Policy Holder Last Name _____ Policy No. _____
 Policy Holder First Name _____ ID/Certificate No. _____

For WSIB Claims Only: OHIP No. _____ WSIB Claim No. _____

For Auto Insurance Claims Only: Auto Insurance Company _____

Address _____ Phone/Fax _____
 Claim No. _____ Policy No. _____
 Date of Accident (dd/mm/yyyy) ___/___/___ Adjustor Name _____

Family Physician

Name _____
 Address _____
 Phone _____
 Fax _____

How did you hear about us?

Doctor ___ Friend ___ Media ___ Walk-In ___
 Insurance Company ___ Family Member ___ Other ___
 Referral Source's Name (Optional) _____

Contact in case of Emergency

Name _____ Relationship _____
 Home Phone _____ Work Phone _____

SERVICE	TOTAL FEE
Physiotherapy Assessment	\$ 90.00
Physiotherapy Treatment per unit	\$ 65.00
Physiotherapy Re-assessment *greater than six months since last assessment or new complaint	\$ 90.00

N.B. Fees are subject to change.

01/03/2013

****Our cancellation policy requires 24 hours notice or you will be charged 100% of the fee****

This signed form and photocopies of this signed form will serve as authorization to the Physio in the Six Clinic to obtain/release medical information pertaining to myself from/to my family physician and to other Physio in the Six Clinic practitioners. It also serves as an agreement to provide payment to Physio in the Six Clinic, at the time of each visit, and later claim through any extended health benefits plan, as appropriate. The undersigned has read and understands the cancellation policy.

Signature _____

Date (dd/mm/yyyy) ___/___/___

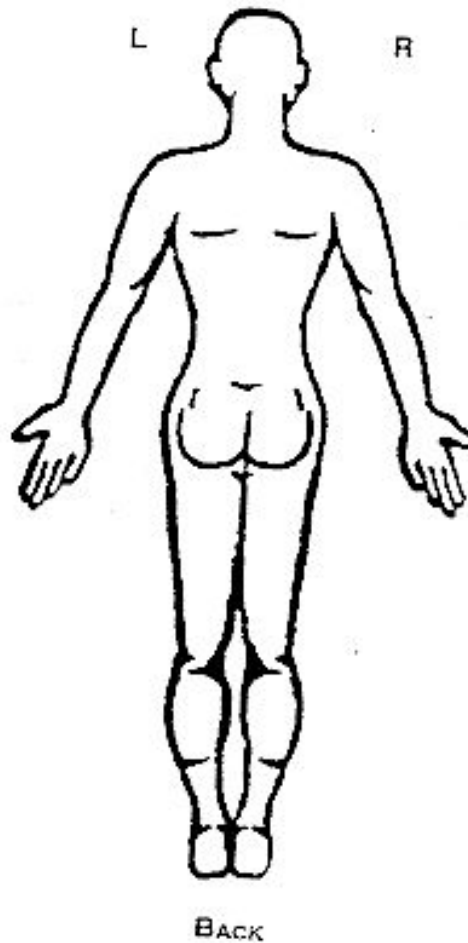
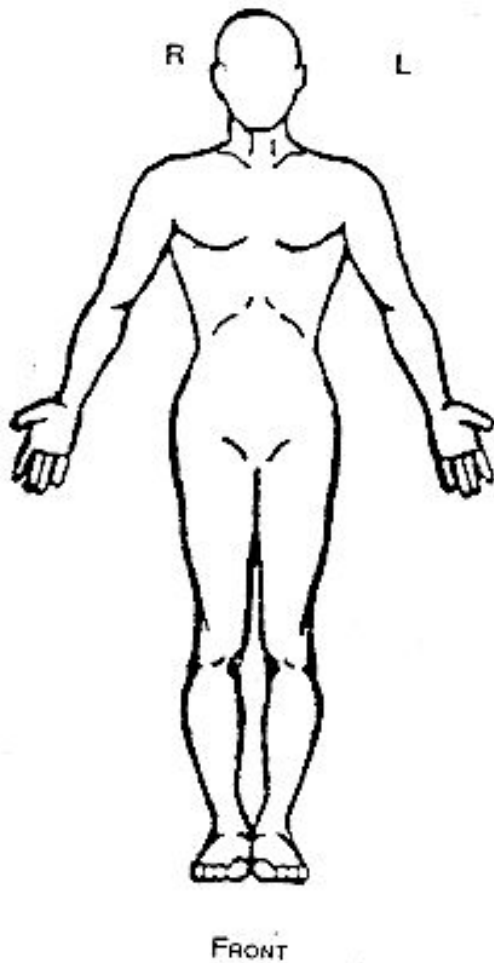


Physio in the Six Symptom Diagram

In the diagrams provided below, please mark the areas on your body that you feel best represent the pain or sensation you are experiencing. Please include all areas. Use the symbols provided below.

Symbols

Numbness	===	Pins & Needles
Burning	XXX	Stabbing & Sharp	/////
Dull & Aching	+++	Stiff & Tight	222



**Patient's Name: _____

**Date of Birth: (dd/mm/yyyy) ___/___/___

Physio in the Six
CONFIDENTIAL HEALTH PROFILE

Name: _____

D.O.B.: (dd/mm/yyyy) ____/____/____

Please complete by checking boxes that apply to you

Heart/Circulatory Conditions

Injury Affecting Sleep

Yes No

Dizziness/Fainting

Blood Pressure

High Low

Muscle/Joints-Pain/Tension

Accidents/Fractures/Surgeries

Neck

(Location & Date)

Shoulders

Elbows

Back *(upper, mid, lower)*

Hips

Knees

Other _____

Rheumatoid Arthritis

Medications *(List all)*

HIV/AIDS

Skin Conditions/Bruising

Digestive/Urogenital Conditions

Breathing/Respiratory Conditions

Any other information your treating practitioner should be aware of?

Pacemaker

Heart Arrhythmia

Diabetes

Cancer

For Women

Pregnant?

Number of weeks _____

Due Date _____

Exercise Activity

(Type & Frequency)

****Patient's Initials** _____



**Physio in the Six
PHYSIOTHERAPY CONSENT TO TREATMENT**

I hereby consent to the assessment and treatment performed by the Registered Physiotherapist named below.

I understand that treatment may include treatments for therapeutic, preventative, palliative, diagnostic, cosmetic, or other health related purposes.

I understand that I may rescind or amend this consent in writing.

I further understand that the clinical, psychological and any other information which is gathered during the course of my treatment is confidential, but may be shared with my insuring agents, third party payers and/or physician(s) upon request.

I have read the above consent, and I have had the opportunity to ask questions about its content. This consent will cover the physiotherapy assessment and entire course of treatment.

Patient's Name (*Please print*)

Physiotherapist's Name (*Please print*)

Date of Birth: (*dd/mm/yyyy*) ____/____/____

Signature of Patient

Date Signed

The Health Information Custodian of this chart is Physio in the Six.

Physio in the Six
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Toronto, ON
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