



GREATER TORONTO REHABILITATION CLINICS
PHYSIOTHERAPY, CHIROPRACTIC,
FOOT CARE & SPORTS INJURY

East Liberty Physio Clinic Royal Physio Clinic Vaughan Clinic Wishing Well Clinic
Home Care King West Club Simcoe Place

All information will be held in strict confidence.

Last Name _____ First Name _____ Initial _____

Date of Birth (dd/mm/yyyy) ____/____/____ Occupation _____

Address _____ Postal Code _____

Work Phone _____ Home Phone _____ Cell Phone _____

Email _____

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

For Auto Insurance Claims Only:

Insurance Company _____ Phone _____ Address _____

Claim No. _____ Policy No. _____ Date of Accident (dd/mm/yyyy) ____/____/____

Adjustor Name _____ Adjustor Phone Number _____

Family Physician

Name _____

Address _____

Phone _____

Fax _____

How did you hear about us?

Doctor ____ Friend ____ Media ____ Walk-In ____

Insurance Co. ____ Family Member ____ Other ____

Referral Source's Name (Optional) _____

Contact in case of Emergency

Name _____

Relationship _____

Home Phone _____

Work Phone _____

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 Greater Toronto Rehabilitation Clinics to obtain/release medical information pertaining to myself from/to my family physician and to other Greater Toronto Rehabilitation Clinics practitioners. It also serves as an agreement to provide payment to Greater Toronto Rehabilitation Clinics, 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.

Patient Signature: _____

Date: _____

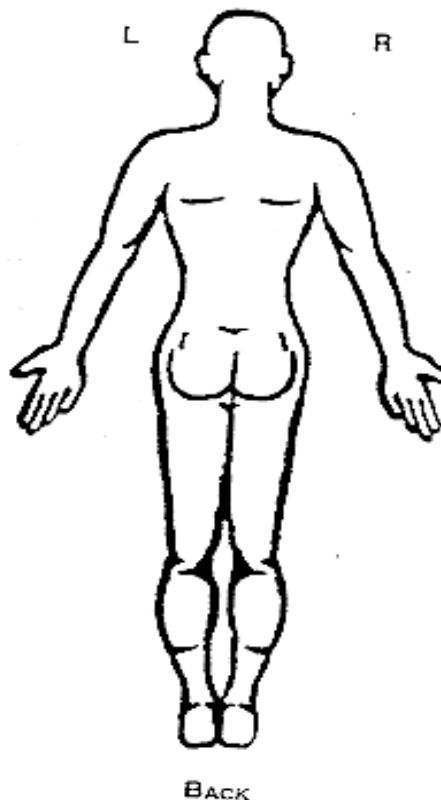
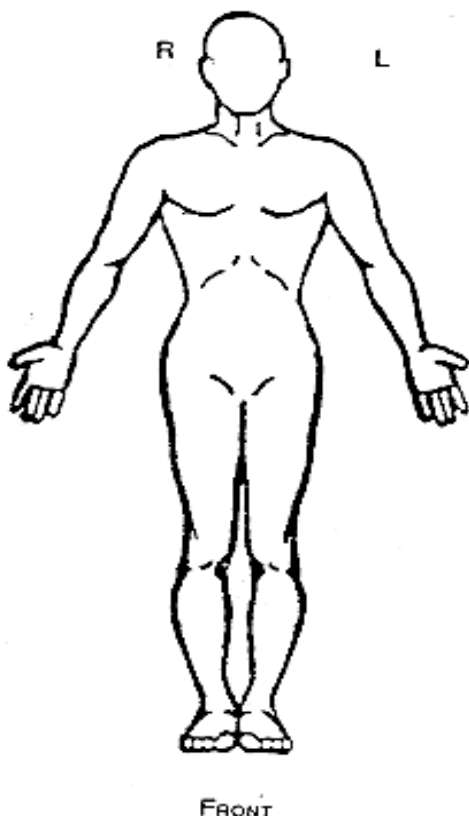


SYMPTOM DIAGRAM

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: _____

Patient's Date of Birth: _____

Date: _____



CONFIDENTIAL HEALTH PROFILE

Please complete by checking boxes that apply to you

Heart/Circulatory Conditions	<input type="checkbox"/>	Injury Affecting Sleep Yes <input type="checkbox"/> No <input type="checkbox"/>
Dizziness/Fainting	<input type="checkbox"/>	Blood Pressure High <input type="checkbox"/> Low <input type="checkbox"/>
Muscle/Joints-Pain/Tension	<input type="checkbox"/>	Accidents/Fractures/Surgeries
Neck	<input type="checkbox"/>	(Location & Date):
Shoulders	<input type="checkbox"/>	_____
Elbows	<input type="checkbox"/>	_____
Back (upper, mid, lower)	<input type="checkbox"/>	_____
Hips	<input type="checkbox"/>	_____
Knees	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	_____
Rheumatoid Arthritis	<input type="checkbox"/>	Medications (List all):
HIV/AIDS	<input type="checkbox"/>	_____
Skin Conditions/Bruising	<input type="checkbox"/>	_____
Digestive/Urogenital Conditions	<input type="checkbox"/>	_____
Breathing/Respiratory Conditions	<input type="checkbox"/>	Any other information your treating practitioner should be aware of?
Diabetes	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	_____
For Women: Pregnant?	<input type="checkbox"/>	_____
Number of weeks _____		_____
Due Date _____		_____
Exercise Activity		
(Type & Frequency)		

Patient's Name: _____

Patient's Date of Birth: _____

Date: _____



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CONSENT TO TREATMENT

I hereby consent to the assessment and treatment performed by the Practitioner 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 rehabilitation assessment and entire course of treatment.

Patient's Name (*Please print*)

Practitioner's Name (*Please print*)

Signature of Patient

Patient's Date of Birth

Date Signed

**East Liberty
Physiotherapy Clinic**
901 King Street West, Suite 105
Toronto, ON M5V 3H5
(416) 599-6000, x2

Royal Physiotherapy Clinic
130 Adelaide Street West
Toronto, ON M5H 3P5
(416) 361-6142, x204

**Vaughan Physiotherapy,
Chiropractic, and Foot Care Clinic**
Piazza Del Sole
200 Windflower Gate, Unit 700
Vaughan, ON L4L 9L3
(905) 264-0250, x3

**Wishing Well Physiotherapy,
Chiropractic, and Foot Care Clinic**
12637 Tenth Line
Stouffville, ON L4A 2X5
(905) 591-6060, x5

**The Health Centre at
The King West Club**
266 King Street West
Toronto, ON M5V 1H8
(416) 260-9911

**The Health Centre at
Simcoe Place**
200 Front Street West
Toronto, ON M5J 2N1
(416) 913-9123