



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

East Liberty Physio Clinic  Ellesmere Markham Clinic  King West Club  Simcoe Place   
Royal Physio Clinic  Wishing Well Clinic  Ultimate Athletics Club  Vaughan Clinic  Home Care

**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:** \_\_\_\_\_

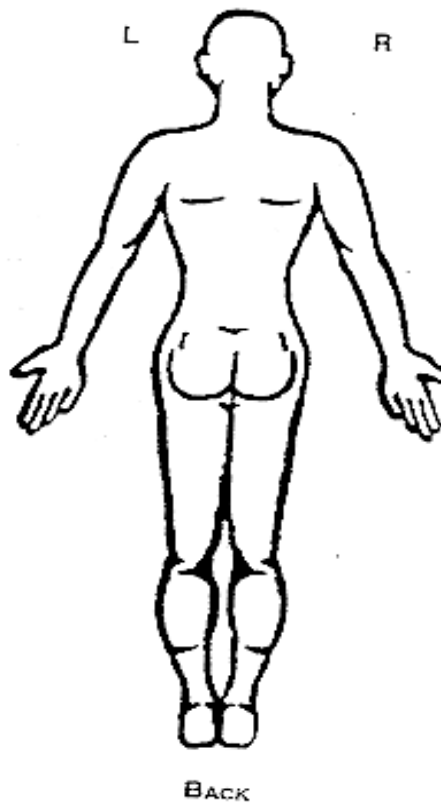
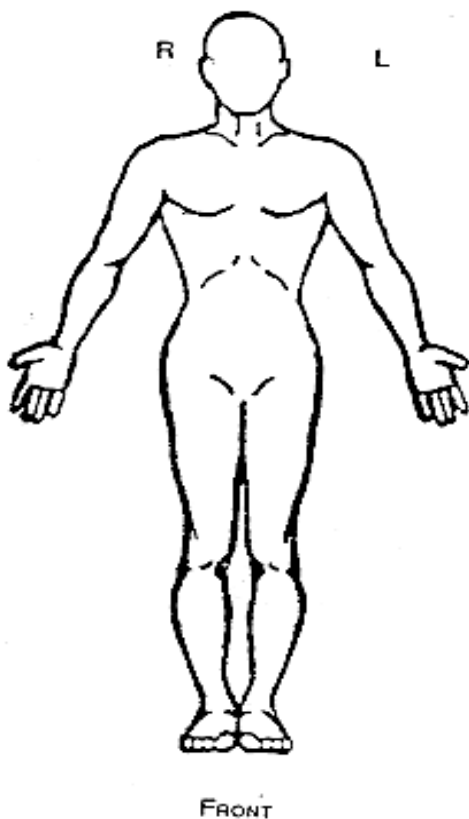


## SYMPTOM DIAGRAM

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*

<b>Heart/Circulatory Conditions</b>	<input type="checkbox"/>	<b>Injury Affecting Sleep</b> Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Dizziness/Fainting</b>	<input type="checkbox"/>	<b>Blood Pressure</b> High <input type="checkbox"/> Low <input type="checkbox"/>
<b>Muscle/Joints-Pain/Tension</b>	<input type="checkbox"/>	<b>Accidents/Fractures/Surgeries</b>
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"/>	_____
<b>Rheumatoid Arthritis</b>	<input type="checkbox"/>	<b>Medications (List all):</b>
<b>HIV/AIDS</b>	<input type="checkbox"/>	_____
<b>Skin Conditions/Bruising</b>	<input type="checkbox"/>	_____
<b>Digestive/Urogenital Conditions</b>	<input type="checkbox"/>	_____
<b>Breathing/Respiratory Conditions</b>	<input type="checkbox"/>	<b>Any other information your treating practitioner should be aware of?</b>
<b>Diabetes</b>	<input type="checkbox"/>	_____
<b>Cancer</b>	<input type="checkbox"/>	_____
<b>For Women: Pregnant?</b>	<input type="checkbox"/>	_____
Number of weeks _____		_____
Due Date _____		_____
<b>Exercise Activity</b>		
(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, Ext. 222

**Ellesmere Markham  
Physiotherapy Clinic**  
2060 Ellesmere Road, Unit 1  
Toronto, ON M1H 2V6  
(416) 439-8900

**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

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

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

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

**Ultimate Athletics Club**  
1216 Yonge Street  
Toronto, ON M4T 1W1  
(416) 922-8181