PARKWAY
PHYSIOTHERAPY + PERFORMANCE CENTRE

Name on Care Card_____

Preferred Name_____

Phone (_____)_____--_____ Home/Cell/Work

Phone(_____)_____--_____ Home/Cell/Work

Email for appointment reminders/communication/newsletter:
(by providing an email I consent to Parkway's use of that email in communication)

_____

Care Card Number

_____

Date of Birth _____/_____/_____
Month Day Year

Address:_____

_____

City_____Post Code_____

Emergency Contact Name:_____ Phone: _____

- Parkway has a 24 hour notice cancellation policy for your reserved space, for failing to observe this policy you may incur a $25 reservation fee.
- Providing the following information is interpreted as consent to share details pertinent to your case with those individuals mentioned below and is in force for 2 years. ** For the protection of your privacy, revocation of this given consent is preferred in writing**

Referring Doctor (first name) _____ (last name) _____

Family Doctor (first name) _____(last name) _____

- All Services are paid directly by the patient unless a third party funder provides coverage. A user fee applies to all MSP and ICBC visits and is due at the time of service.

Worksafe BC Only --Please provide all information below as it is required to bill Worksafe BC on your behalf.

Date of Injury (M)____/(D)____/(Y)_____ Claim #_____

Referring Doctor_____Employer Name_____

Company and telephone contact #_____

Case Manager_____Phone(_____)_____--_____

ICBC only-- Please provide all information below as it is required to bill ICBC on your behalf.

Date of Accident (M)____/(D)____/(Y)_____ Claim #_____

Where you a pedestrian/cyclist or passenger in this accident? Yes/No

Are you currently attending massage therapy under this claim? Yes/No

Adjuster_____ Phone(_____)_____--_____

Lawyer (?)_____ Phone(_____)_____--_____

MSP Premium assistance (Care Card will be verified)

I wish to assign all reimbursements for benefits payable to me to Parkway Physiotherapy + Performance Centre for care provided to me. I am aware that I am responsible for all outstanding balances. Signed _____ Date(M)____/(D)____/(Y)_____

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Name:_____ Date of Birth:_____

Primary Concern(s)? **How did it happen?**

1._____ _____

_____

New or **Old**?(circle) **How long since it started**_____

_____

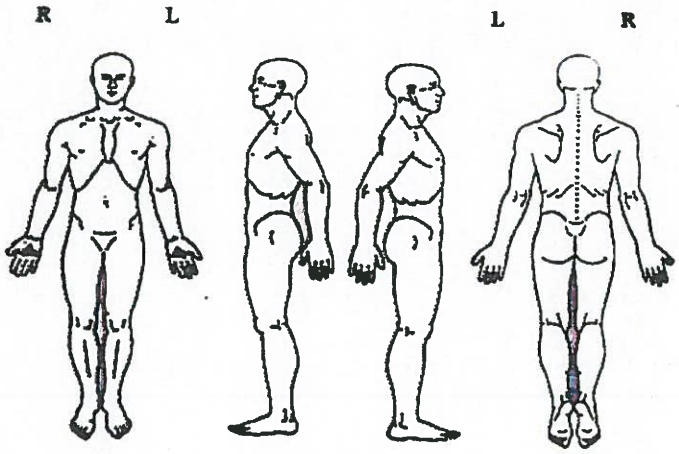
2._____ _____

_____

New or **Old**?(circle) **How long since it started**_____

_____

Please indicate on the body diagram where you feel pain/discomfort.



To rate your pain at this time, please draw an X on the line below.

0_____10

No Pain

Extreme Pain

What aggravates or makes your pain worse?

_____

_____

What eases or makes your pain better?

_____

_____

Have you had any diagnostic tests such as an X-Ray, MRI, CT Scan or other for this problem?

Please list any medications you are currently taking.

_____

_____

Please list any allergies you may have:

_____

Previous injuries: _____

_____

_____

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Name:_____ Date of Birth:_____

Emotional Health:

A: Recently I've been feeling: (On a scale of 1=Rarely to 10 = Always)

Anger	Sadness	Fear	Guilt	Pain	Happiness	Contentment

B: Accepting and expressing my emotion is

Impossible ----------Easy to do

1 5 10

Do you suffer from any health problems/conditions. (indicate NO or describe below)
If YES to any of the below please describe: _____

_____

_____

- Women, are you pregnant? No __ Yes____Number of weeks_____

	YES		YES
• Cancer or Previous Cancer	___	• Connective tissue disorder	___
• Lung Condition	___	Marfans	___
• Heart Condition	___	Ehlers-Danlos	___
• Circulatory Condition	___	Osteogenisis Imperfecta	___
• Diabetes	___	Hypermobility Syndrome	___
• Asthma	___	Achondroplasia	___
• Bone Disorder	___	• Endocrine Disorders	___
Osteoporosis	___	Hypothyroidism	___
Osteopenia	___	Hyperthyroidism	___
Pagets	___	• Arthritis	___
• Blood/Bleeding Disorder	___	Rheumatoid	___
Haemophelia	___	Psoriatic	___
• Seizures	___	AKS	___
• HIV/HEPATITIS A/B/C	___	Reiters	___
		• OTHER –not mentioned?	___

What is your occupation? _____
What duties does your occupation require(3-5 things)_____

_____

How do you like to spend your spare time?_____

_____

What is your goal of treatment?

☐Pre-activity/sports assessment? ☐Advice about injury prevention?

☐Help with a specific problem? ☐ Other _____

How did you hear about us? Yellow pages, Friend/Family? (name) _____ _,
Community event, Doctor, Drive by, Internet, Radio TV, other:_____

By signing below you are agreeing that your therapist may use this information to assist in forming an individual treatment plan for you.

Signature_____ Date_____