



Client Intake Form

WSIB

Date: _____

Patient Name (Last, First): _____

Address: _____

Street _____ City _____ Postal Code _____
Date of Birth: (month/day/year) _____ Gender: Male _____ Female _____

Telephone: (H) _____ (Work) _____ (Cell) _____

Family Dr.: _____ Specialist: _____

Referred By: _____ Email: _____ yes can use

Emergency Contact: _____ Phone #: _____

Current Area of Injury: _____

Repeat Patient: Yes _____ No _____ Last Date at Clinic: _____

Type of Injury: Work _____ Sports _____ Post-op _____ Other _____

Possible Funding Sources: Extended Health Care (EHC) _____ Employer _____ Other _____

How did you find out about the clinic? _____

Education level completed: Primary _____ Secondary _____ Post - Secondary _____ Trade _____

Employment Information

Are you currently working? Yes _____ No _____ Do you have a job to return to? Yes _____ No _____ Modified? Yes _____ No _____

Occupation: _____ Employer: _____

Address: _____ Employer Contact: _____

Is it okay to talk to employer: Yes _____ No _____ How many years with employer: _____

Claim Information

Original Date of Accident (month/day/year): _____ Post-Op/Recurrence Date: _____

S.I.N.: _____ Claim #: _____

WSIB Case Manager: _____ Phone #: _____ Fax #: _____

WSIB Nurse Case Manager: _____ Phone #: _____ Fax #: _____

Has the Employer completed forms: Yes _____ No _____ Has the Physician completed forms: Yes _____ No _____

Have you completed your forms: Yes _____ Not Yet _____

Do you have Extended Health Coverage if your claim is Denied? Yes _____ No _____

Extended Health Insurance (EHC)

Name of Insurance Carrier: _____ Policy #: _____ Claim #: _____

Name of Certificate/Policy Holder: _____ Date of Birth: _____ Relationship: _____

Per Year Limit: \$ _____ Per Treatment Limit: \$ _____ Treatment # Limit: _____

No Show Policy Agreement:

The clinic requires at least 24 hours notice of a cancellation, unless an unforeseen incident (eg. Waking up with the flu, flat tire). We allow 1 late cancellation before a \$25.00 fee will be charged which must be paid prior to your next appointment.

Agree to terms, please sign: _____

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