St. Catharines Physiotherapy Centre

Client Intake Form

PRIVATE **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

Working: Yes ___ **No** ___ **Work Status: Full Time**___ **Part Time** ___ **Modified**___ **Retired**___ **Student**___ **Homemaker**___

If not working is it due to the injury? Yes ___ **No** ___ **Do you have a job to return to? Yes** ____ **No** ____

Occupation: _____ **Employer:** _____

Address: _____ **Employer Contact:** _____

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

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: _____