SUNSHINE PHYSIOTHERAPY

Thank you for choosing Sunshine Physiotherapy for your Physiotherapy care. For your first visit today, you will undergo a complete orthopedic examination to ensure the most effective treatment is provided to you. Your first visit will be approximately 45 minutes. Please feel free to ask questions and relate concerns you may have to your therapist. We would like your experience here to be comfortable and educational too!

Client Name: _____

Street Address: _____

City: _____ Province: _____ Post Code: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____

□ I agree to receive Sunshine Physiotherapy's Newsletter via email and understand I can withdraw my consent at any time.

Appointment Reminders by:
Email □ Phone Home □ Cell □

□ I agree to receive Sunshine Physiotherapy's appointment reminders via email and understand I can withdraw my consent at any time.

Date of Birth (yyyy/mm/dd): _____ Date of Injury if applicable: _____

Occupation: _____ Alberta Heath Care # _____

Family Doctor: _____ Referring Doctor _____

Phone: _____ Fax: _____ Phone: _____ Fax: _____

Family Dr. Clinic: _____

Emergency Contact Person: _____ Phone: _____

Source of Referral: _____ (Mark if applicable):

Physician _____ Yellow Pages_____ Resource Book_____

Word of Mouth _____ Website _____ Newspaper _____

I understand that the cost of PHYSICAL THERAPY treatment at this clinic is not covered by Alberta Heath Care or the Calgary Regional Health Authority or Workers Compensation Board.

I understand that payment is due at the time of the appointment and the fee for my **initial assessment is $130.00 and $115.00 per 45 minute treatment thereafter.** I understand that payment is required before treatment commences. Please note that individual benefit plans vary in the amount of the funding available to each client. It is the responsibility of the client to be aware of their individual plan.

I understand that I will be charged for failing to attend my appointment or canceling without 24 hours notice. **I understand the fee for each missed appointment or late cancellation is $115.00 per 45 minute session and is due prior to my next scheduled appointment.** If I am late for my appointment, I understand that I will be treated for the remainder of the time left from my 45 minute session.

Please sign below in acknowledgement, understanding and acceptance for this payment agreement:

Signature: _____ Date: _____
If under 18 years of age, must be signed by a parent or guardian.

Main problem in my own words and date pain started: (approx) :

_____
_____
_____
_____

Other medical problems:

_____
_____
_____

Investigations: (X-ray, MRI etc.)

_____
_____

Please indicate with an X the following that apply to you:

____ Migraines
____ Tension headaches
____ Loss of sleep
____ Heart disease
____ Pace Maker
____ Diabetes
____ Circulatory Disorders
____ Metal Implant
____ Breathing disorders
____ IUD
____ Osteoporosis
____ Hepatitis A,B,C
____ Epilepsy
____ High/Low Blood pressure
____ HIV/Aids
____ Cancer
____ Drug Allergies
____ Bleeding disorders
____ Pregnancy
____ Anticoagulants
____ Thyroid
____ Arthritis
____ Ulcer
____ Psychiatric
____ Joint Pain
____ Chronic Pain
____ Numbness/Tingling

List of medications:

_____
_____

Do you smoke? Y/N ____ How many packs per day? _____
Do you use medicinal marijuana? Y/N ____

Allergies:

_____

If you had other treatments what were they?

_____
_____
_____

Informed consent to physical therapy intervention

Your physiotherapy treatment in this facility could involve any of the following techniques:

1: Education regarding your condition, including the relevant anatomy, pathology and joint mechanics.

2: Home program to best manage the condition. This may include stretching and strengthening exercises, mobilizing techniques and techniques to manage soft tissue pain including trigger points.

3: Manual therapy: This may include mobilization or manipulation techniques. These are applied to a joint that does not move appropriately with the intent of restoring more normal joint mechanics. Mobilizations are slow, rhythmical movements while manipulations are quick high amplitude movements applied locally to a joint. I understand and am informed that, as in all health care, in the practice of physical therapy there are some risks to treatment, including, but not limited to, muscle strains and sprains, disc injury and strokes.

4: Traditional Chinese Acupuncture **(**TCM**)** uses a fine and flexible needle to acquire the Qi along meridians. A branch of TCM is dry needling or "Ah-Shi" points where one inserts the needle into the tight muscle. No drugs are injected.

Traditional Chinese Acupuncture is a valuable treatment for pain, like any medical procedure there are possible complications. While these complications are rare in occurrence they are real and must be considered prior to giving consent to the procedure.

Any time a needle is used there is a risk of infection, **Sunshine Physiotherapy** uses new disposable sterile needles and infections are rare. A needle may be placed inadvertently in an artery, nerve or vein. If an artery or vein is punctured with the needle a hematoma (bruise) will develop. If a nerve is punctured it may cause paresthesia (a prickling sensation) which may continue for a short time. When a needle is placed close to the chest wall there is a rare possibility of a pneumothorax (air in the chest cavity). Fortunately, all these complications are not fatal and are readily reversible.

Dry Needling or "Ah-Shi" points may cause tenderness for one or two days followed by improvement in overall pain state.

5: Intramuscular Stimulation (IMS). This is the treatment of muscular trigger points using an acupuncture needle. This helps to release the trigger point and allow for more effective stretching and retraining of the muscle. Complications of needling are rare but can include bruising, bleeding (these are the most common) bent or broken needles, soreness and damage to internal organs.

I have read the preceding information and understand the risks that are related to certain techniques. I respect my right to be a partner in my treatment program and to have the right to refuse specific treatment techniques once the risks vs. benefits have been explained.

_____	_____
Patient name print	Patient signature (or guardian)
_____	_____
Date signed	Physical therapist

Consent to release information:

I hereby authorize this clinic to release information to my physician, insurance company, employer and/or lawyer. I hereby authorize my physician or any medical offices to release information to my physiotherapist.

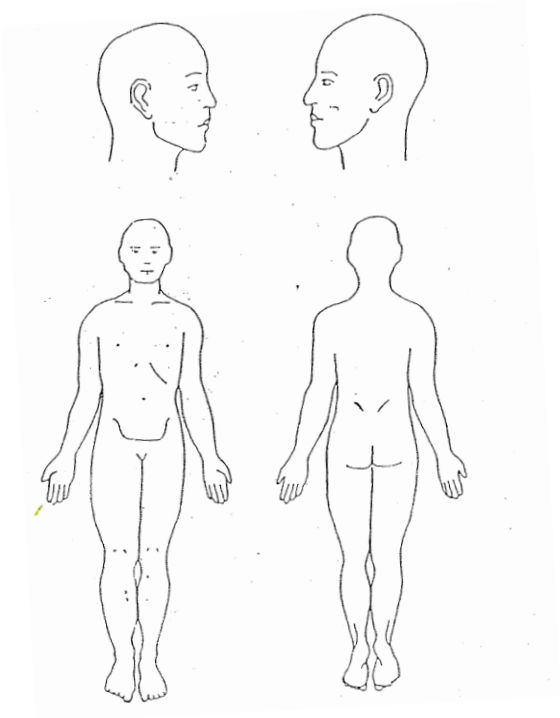
Name: _____
Please print your name

Signature: _____ Date: _____
If under 18 years of age, must be signed by a parent or guardian.

Information reviewed and confirmed by Physical Therapist: _____

Screening Questionnaire

Using the figure(s), please shade in the areas in which your pain is located. Be sure to point out how much area is involved. Does it vary in intensity? Does your pain spread? Please write an X on the figure(s) below to indicate the area of worst pain and draw arrows to show where it spreads.



We offer direct invoicing through Telus eClaims payors from the list below. You will still pay us directly for the full amount of your treatment but we will be able to submit the claim on your behalf.

Please indicate if you have coverage under one of the following plans:

- ☐ Chambers of Commerce Group Insurance Plan
- ☐ Cowan
- ☐ First Canadian Insurance Corporation
- ☐ iA Financial Group
- ☐ Johnston Group
- ☐ Maximum Benefit
- ☐ CINUP
- ☐ Desjardins Insurance
- ☐ Johnson
- ☐ Manulife
- ☐ Sun Life Financial

Policy Holder: ☐ Yourself ☐ Spouse/Parent

Policy Number: _____

ID# of Policy Holder: _____

Injury Date: _____

If covered under a spouse or parent:

Spouse/Parent's Full Name: _____

Spouse/Parent's Date of Birth: _____

Spouse/Parent's Address: _____