



## PATIENT INFORMATION FORM

It is the policy of Peak to Shore Physiotherapy and Sports Medicine that all Personal Health Information (PHI) and Personal Information (PI) collected, used, and maintained shall be treated as confidential and in accordance with the Freedom of Information Protection of Privacy Act (FIPPA), the Personal Health Information Protection Act (PHIPA), and any other applicable legislation. As a Health Information Custodian (HIC), Peak to Shore Physiotherapy and Sports Medicine has an obligation to collect, use and disclose PHI and PI in a manner that protects the confidentiality and privacy of the information. If you have any questions, please discuss with your healthcare provider, the administrative team, or the Clinic Manager.

**General Information (Please Print):**

First name:		Preferred name:	
Last name:		Alternate last name:	
<b>Sex:</b> <input type="radio"/> Female <input type="radio"/> Male  <small>(This field may be used when submitting claims to your insurance provider. Please ensure the sex you indicate matches what your insurance provider has on file)</small>	<b>Gender:</b> <input type="radio"/> Female <input type="radio"/> Male <input type="radio"/> Non-binary Two-Spirit <input type="radio"/> Prefer not to answer  <small>(Refers to current gender which may be different than what is indicated on your insurance policy or medical record)</small>	<b>Pronouns:</b> <input type="radio"/> She/her <input type="radio"/> He/him <input type="radio"/> They/them <input type="radio"/> Prefer not to answer	<b>Do you identify as any of the following:</b> <input type="radio"/> First Nations <input type="radio"/> Inuit <input type="radio"/> Métis <input type="radio"/> None of the above <input type="radio"/> Prefer not to answer
Date of birth (DD/MM/YYYY):			
Mailing address:			
City:		Postal code:	
Primary daytime telephone:		Secondary daytime telephone:	

Name: \_\_\_\_\_  
DOB (DD/MM/YYYY): \_\_\_\_\_



Occupation:		Alternate telephone:	
E-mail address:			
Reason for visit:			
How did you hear about our clinic: <ul style="list-style-type: none"><li><input type="radio"/> Referred by doctor or healthcare provider Name: _____</li><li><input type="radio"/> Referred by a friend or family member</li><li><input type="radio"/> Google/online search</li><li><input type="radio"/> Social media (e.g. Instagram, Facebook)</li><li><input type="radio"/> Walk-in/signage</li><li><input type="radio"/> Community event or outreach Which event? _____</li></ul>			
Are you here to see a specific provider/therapist? <ul style="list-style-type: none"><li><input type="radio"/> Yes Name: _____</li><li><input type="radio"/> No</li></ul>			
Emergency contact:		Telephone:	Relationship:
Family doctor:			Telephone:
If patient is under 16 years of age, indicate name of parent/guardian:			Telephone:
Were your injuries sustained in a <b>motor vehicle accident?</b> (If YES, contact administration before continuing.)			Yes <input type="checkbox"/> No <input type="checkbox"/>
Were your injuries sustained in a <b>workplace injury?</b> (If YES, contact administration before continuing.)			Yes <input type="checkbox"/> No <input type="checkbox"/>



**Health history: This information is required to provide you with safe and effective assessment and treatment.**

Please check all conditions that you are experiencing or have previously experienced.

<u>Musculoskeletal</u>	<u>Nervous System</u>	<u>Cardiovascular</u>
<ul style="list-style-type: none"> <li><input type="radio"/> Tension headache/migraine</li> <li><input type="radio"/> Whiplash injury</li> <li><input type="radio"/> Neck pain</li> <li><input type="radio"/> Shoulder pain</li> <li><input type="radio"/> Arm pain/numbness/tingling</li> <li><input type="radio"/> Low back pain</li> <li><input type="radio"/> Hip pain</li> <li><input type="radio"/> Leg pain/numbness/tingling</li> <li><input type="radio"/> Jaw pain/TMJ</li> <li><input type="radio"/> Tendonitis</li> <li><input type="radio"/> Bursitis</li> <li><input type="radio"/> Muscle spasm or cramps</li> <li><input type="radio"/> Muscle strain</li> <li><input type="radio"/> Joint sprain</li> <li><input type="radio"/> Fracture</li> <li><input type="radio"/> Rheumatoid arthritis</li> <li><input type="radio"/> Osteoarthritis</li> <li><input type="radio"/> Fibromyalgia</li> <li><input type="radio"/> Scoliosis</li> <li><input type="radio"/> Herniated/degenerative disc</li> <li><input type="radio"/> Osteoporosis/osteopenia</li> </ul>	<ul style="list-style-type: none"> <li><input type="radio"/> Numbness/tingling</li> <li><input type="radio"/> Shingles</li> <li><input type="radio"/> Epilepsy/seizures</li> <li><input type="radio"/> Loss of coordination</li> <li><input type="radio"/> Loss of sensation</li> <li><input type="radio"/> Vision loss</li> <li><input type="radio"/> Hearing loss</li> <li><input type="radio"/> Chronic pain</li> <li><input type="radio"/> Weakness</li> <li><input type="radio"/> Multiple Sclerosis</li> <li><input type="radio"/> Parkinson’s Disease</li> <li><input type="radio"/> Cerebral palsy</li> <li><input type="radio"/> Depression</li> <li><input type="radio"/> Anxiety</li> <li><input type="radio"/> Concussion</li> <li><input type="radio"/> Acquired brain injury</li> </ul>	<ul style="list-style-type: none"> <li><input type="radio"/> High blood pressure</li> <li><input type="radio"/> Low blood pressure</li> <li><input type="radio"/> Heart attack</li> <li><input type="radio"/> Angina/chest pain</li> <li><input type="radio"/> Stroke (CVA)</li> <li><input type="radio"/> Transient ischemic attack (TIA)</li> <li><input type="radio"/> Congestive heart failure</li> <li><input type="radio"/> Hemophilia</li> <li><input type="radio"/> Pacemaker or similar device</li> <li><input type="radio"/> Lymphedema</li> <li><input type="radio"/> Chronic swelling</li> <li><input type="radio"/> Light headedness/dizziness</li> <li><input type="radio"/> Blood clots</li> <li><input type="radio"/> Phlebitis</li> <li><input type="radio"/> Varicose veins</li> <li><input type="radio"/> COVID-19</li> </ul>
<u>Respiratory</u>	<u>Digestive</u>	<u>Genitourinary</u>
<ul style="list-style-type: none"> <li><input type="radio"/> Chronic cough</li> <li><input type="radio"/> Chronic bronchitis</li> <li><input type="radio"/> Emphysema</li> <li><input type="radio"/> Shortness of breath</li> <li><input type="radio"/> Asthma</li> <li><input type="radio"/> COPD</li> <li><input type="radio"/> Smoking- Quit? Y N</li> </ul>	<ul style="list-style-type: none"> <li><input type="radio"/> Constipation</li> <li><input type="radio"/> Bloating/gas</li> <li><input type="radio"/> Nausea</li> <li><input type="radio"/> Vomiting</li> <li><input type="radio"/> Irritable bowel syndrome</li> <li><input type="radio"/> Crohn’s/colitis</li> <li><input type="radio"/> Hypoglycemia</li> <li><input type="radio"/> Jaundice</li> <li><input type="radio"/> Liver or gallbladder</li> <li><input type="radio"/> Ulcers</li> <li><input type="radio"/> Reflux</li> <li><input type="radio"/> Hernia (type _____)</li> </ul>	<ul style="list-style-type: none"> <li><input type="radio"/> Urinary tract infection-recurring</li> <li><input type="radio"/> Incontinence (bladder or bowel)</li> <li><input type="radio"/> Kidney stones</li> <li><input type="radio"/> Kidney disease</li> <li><input type="radio"/> Prostate issues</li> <li><input type="radio"/> Menstrual irregularities</li> <li><input type="radio"/> Endometriosis</li> <li><input type="radio"/> PCOS</li> <li><input type="radio"/> Pelvic organ prolapse</li> </ul>

Name: \_\_\_\_\_  
 DOB (DD/MM/YYYY): \_\_\_\_\_



**Health history continued:** Please check all conditions that you are experiencing or have previously experienced.

<u>Skin Conditions</u>	<u>Infections</u>	<u>Other</u>
<ul style="list-style-type: none"> <li><input type="radio"/> Allergies/sensitivities- Type of reaction _____</li> <li><input type="radio"/> Rashes</li> <li><input type="radio"/> Athlete's foot</li> <li><input type="radio"/> Warts</li> <li><input type="radio"/> Open sores/cuts</li> <li><input type="radio"/> Eczema</li> <li><input type="radio"/> Psoriasis</li> </ul>	<ul style="list-style-type: none"> <li><input type="radio"/> Hepatitis</li> <li><input type="radio"/> Tuberculosis</li> <li><input type="radio"/> Herpes</li> <li><input type="radio"/> Shingles</li> <li><input type="radio"/> HIV/AIDS</li> <li><input type="radio"/> MRSA</li> <li><input type="radio"/> VRE</li> </ul>	<ul style="list-style-type: none"> <li><input type="radio"/> Diabetes- Type _____</li> <li><input type="radio"/> Thyroid problems</li> <li><input type="radio"/> Lupus</li> <li><input type="radio"/> Pregnant- Weeks _____</li> <li><input type="radio"/> Cancer- Type _____</li> <li><input type="radio"/> Eating disorder</li> <li><input type="radio"/> Hearing device</li> <li><input type="radio"/> Contact lenses/glasses</li> <li><input type="radio"/> Prosthesis</li> <li><input type="radio"/> Artificial joint- Type _____</li> <li><input type="radio"/> Pins/wires/plates/rods- Location _____</li> <li><input type="radio"/> Menopause- peri or post</li> </ul>
<p>Other medical conditions not mentioned above:</p>		
<p>List all current medications and what they are treating:</p>		
<p>List any allergies:</p>		
<p>List all past surgeries, approximate date, any complications, and restrictions:</p>		
<p>List all activities and/or exercises that you participate in and the frequency:</p>		
<p>Overall, how would you rate your general health? (Check one)</p> <p> <input type="checkbox"/> Excellent              <input type="checkbox"/> Very Good              <input type="checkbox"/> Good              <input type="checkbox"/> Poor              <input type="checkbox"/> Very Poor       </p>		

Name: \_\_\_\_\_  
DOB (DD/MM/YYYY): \_\_\_\_\_



What results are you seeking to achieve from the treatment/visit?

Are you currently seeing a health professional for this concern?    Yes     No

If yes, please explain:

Have you previously seen another health professional for this concern?    Yes     No

If yes, please explain:

I hereby certify that the medical information provided above is true, accurate, and complete to the best of my knowledge.

Name (print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date (DD/MM/YYYY): \_\_\_\_\_

Name: \_\_\_\_\_  
DOB (DD/MM/YYYY): \_\_\_\_\_



## CONSENT TO OBTAIN AND/OR FURNISH MEDICAL INFORMATION

I, \_\_\_\_\_, (patient name) hereby consent to and authorize **Peak to Shore Physiotherapy and Sports Medicine** to obtain from and/or furnish information to:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

for the purpose of treatment, care coordination, or administrative requirements. I understand that all information will be handled in accordance with applicable privacy laws and regulations.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: (DD/MM/YYYY) \_\_\_\_\_

Parent/Guardian name if patient is a minor: \_\_\_\_\_ Signature: \_\_\_\_\_

Signature of witness: \_\_\_\_\_ Date (DD/MM/YYYY): \_\_\_\_\_