2917 Lake Shore Blvd, West.
Toronto, Ontario. M8V 1J3
647-748-2917 | PHYSIOINTHESIX.COM

All information will be held in strict confidence.

Last Name______________________________ First Name________________________________ Initial______

Date of Birth (*dd/mm/yyyy*) ____/____/_______ Occupation_______________________________

Address____ City_________________ Postal Code_______________

Email____

Home Phone________________________ Work Phone________________________ Cell Phone ________________________

Direct Billing Information: Insurance Company____

Policy Holder Last Name______________________________ Policy No.______________________

Policy Holder First Name______________________________ ID/Certificate No.______________________

For WSIB Claims Only: OHIP No. ________________________ WSIB Claim No._____________________

For Auto Insurance Claims Only: Auto Insurance Company____

Address__________________________________ Phone/Fax _____________________________

Claim No. ________________________________ Policy No.______________________________

Date of Accident (*dd/mm/yyyy*) ____/____/_______ Adjustor Name __________________________

Family Physician

Name___________________________________

Address_________________________________

Phone___________________________________

Fax ____________________________________

How did you hear about us?

Doctor ____ Friend ____ Media____ Walk-In____

Insurance Company_____ Family Member_____ Other_____

Referral Source's Name (*Optional*)

____

Contact in case of Emergency

Name__________________________________ Relationship_____________________________

Home Phone____________________________ Work Phone_____________________________

SERVICE	TOTAL FEE
Physiotherapy Assessment	**$ 95.00**
Physiotherapy Treatment per unit	**$ 70.00**
Physiotherapy Re-assessment ***greater than six months since last assessment or new complaint**	**$ 95.00**

N.B. Fees are subject to change.

****Our cancellation policy requires 24 hours notice or you will be charged 100% of the fee****

This signed form and photocopies of this signed form will serve as authorization to the Physio In The Six Inc. Clinic to obtain/release medical information pertaining to myself from/to my family physician and to other Physio In The Six Inc. Clinic practitioners. It also serves as an agreement to provide payment to Physio In The Six Inc. Clinic, at the time of each visit, and later claim through any extended health benefits plan, as appropriate. The undersigned has read and understands the cancellation policy.

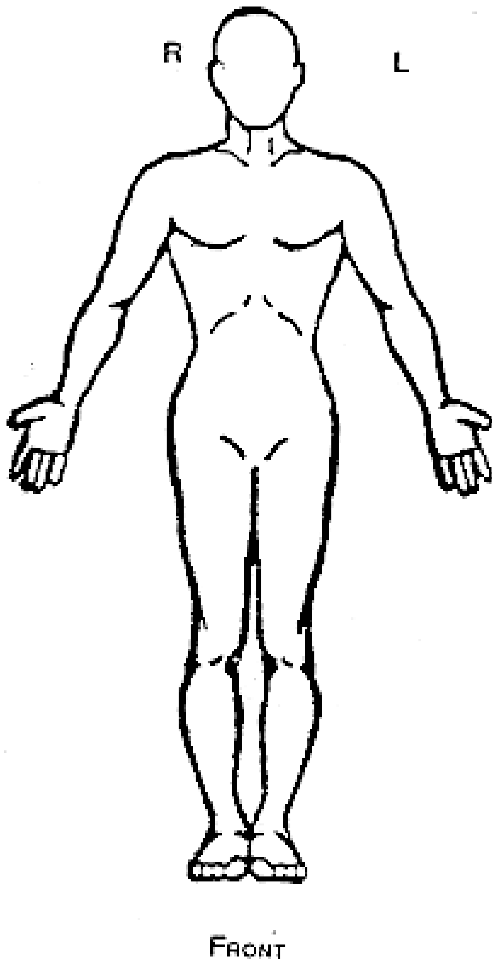
Signature_____________________________________ **Date (*dd/mm/yyyy*)** ____/____/______

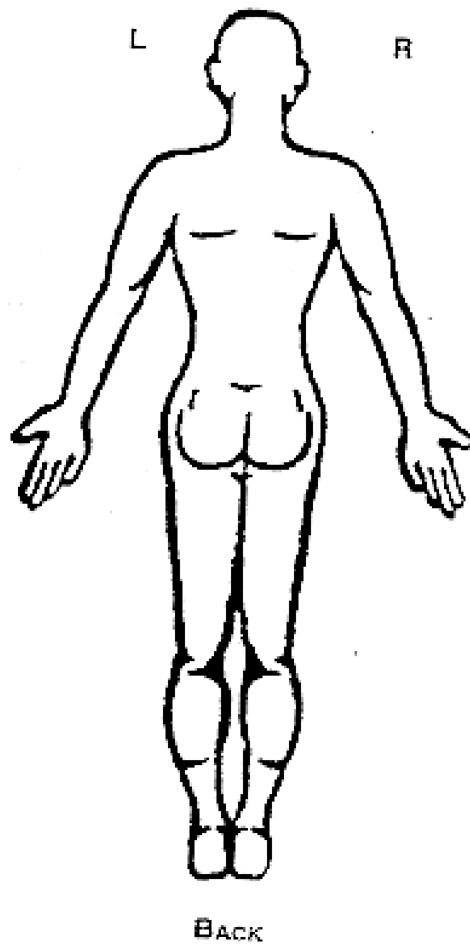
Physio In The Six Inc.
Symptom Diagram

In the diagrams provided below, please mark the areas on your body that you feel best represent the pain or sensation you are experiencing. Please include all areas. Use the symbols provided below.

Symbols

Numbness	===	Pins & Needles	:::::::
Burning	XXX	Stabbing & Sharp	//////
Dull & Aching	+++	Stiff & Tight	222





**Patient's Name: ______________________________

**Date of Birth: *(dd/mm/yyyy)* ____/____/_______

Physio In The Six Inc.
CONFIDENTIAL HEALTH PROFILE

Name:____________________________________

D.O.B.: (*dd/mm/yyyy*) ____/____/_______

Please complete by checking boxes that apply to you

Heart/Circulatory Conditions ❒

Dizziness/Fainting ❒

Muscle/Joints-Pain/Tension ❒
Neck ❒
Shoulders ❒
Elbows ❒
Back *(upper, mid, lower)* ❒
Hips ❒
Knees ❒
Other____________________ ❒

Rheumatoid Arthritis ❒

HIV/AIDS ❒

Skin Conditions/Bruising ❒

Digestive/Urogenital Conditions ❒

Breathing/Respiratory Conditions ❒

Pacemaker ❒

Heart Arrhythmia ❒

Diabetes ❒

Cancer ❒

For Women
Pregnant? ❒
Number of weeks_________
Due Date________________

Injury Affecting Sleep Yes ❒ No ❒

Blood Pressure High ❒ Low ❒

Accidents/Fractures/Surgeries
(Location & Date)

____

____

____

Medications *(List all)*

____

____

____

Any other information your treating practitioner should be aware of?

____

____

____

Exercise Activity
(Type & Frequency)

____

____

____

****Patient's Initials**______

PHYSIO
IN THE SIX

Physio In The Six Inc.

PHYSIOTHERAPY CONSENT TO TREATMENT

I hereby consent to the assessment and treatment performed by the Registered Physiotherapist named below.

I understand that treatment may include treatments for therapeutic, preventative, palliative, diagnostic, cosmetic, or other health related purposes.

I understand that I may rescind or amend this consent in writing.

I further understand that the clinical, psychological and any other information which is gathered during the course of my treatment is confidential, but may be shared with my insuring agents, third party payers and/or physician(s) upon request.

I have read the above consent, and I have had the opportunity to ask questions about its content. This consent will cover the physiotherapy assessment and entire course of treatment.

___________________________________ ___________________________________

Patient's Name (*Please print*) Physiotherapist's Name (*Please print*)

Date of Birth: (*dd/mm/yyyy*) ____/____/________

____

Signature of Patient

____

Date Signed

The Health Information Custodian of this chart is Physio In The Six Inc.

Physio In The Six Inc.
2917 Lake Shore Blvd West
Toronto, ON
M8V 1J3