



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 (45 minutes)	\$ 110.00
Physiotherapy Treatment per unit (30 minutes)	\$ 70.00
Physiotherapy Re-assessment (45 minutes) *greater than six months since last assessment or new complaint	\$ 110.00

N.B. Fees are subject to change.

**\*\*Our cancellation policy requires 24 hours notice or you will be charged 50% 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)** \_\_\_\_/\_\_\_\_/\_\_\_\_

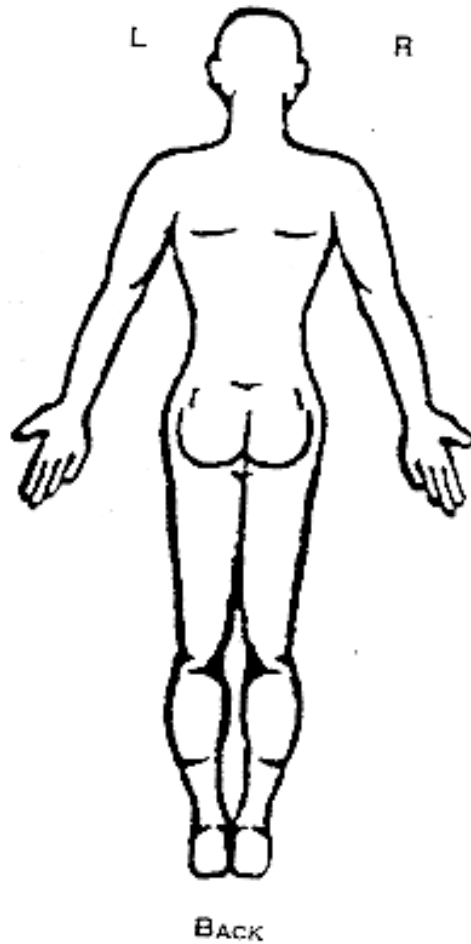
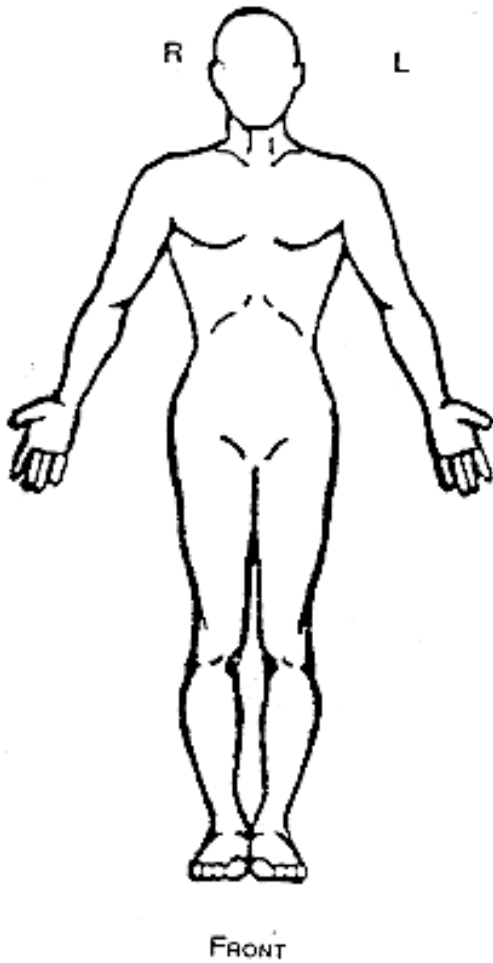


## Physio In The Six Inc. Symptom Diagram

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*

<b>Heart/Circulatory Conditions</b>	<input type="checkbox"/>	<b>Injury Affecting Sleep</b>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Dizziness/Fainting</b>	<input type="checkbox"/>	<b>Blood Pressure</b>	High <input type="checkbox"/> Low <input type="checkbox"/>
<b>Muscle/Joints-Pain/Tension</b>	<input type="checkbox"/>	<b>Accidents/Fractures/Surgeries</b>	
Neck	<input type="checkbox"/>	(Location & Date)	
Shoulders	<input type="checkbox"/>		
Elbows	<input type="checkbox"/>		_____
Back (upper, mid, lower)	<input type="checkbox"/>		
Hips	<input type="checkbox"/>		_____
Knees	<input type="checkbox"/>		
Other _____	<input type="checkbox"/>		_____
<b>Rheumatoid Arthritis</b>	<input type="checkbox"/>	<b>Medications (List all)</b>	
<b>HIV/AIDS</b>	<input type="checkbox"/>		_____
<b>Skin Conditions/Bruising</b>	<input type="checkbox"/>		_____
<b>Digestive/Urogenital Conditions</b>	<input type="checkbox"/>		_____
<b>Breathing/Respiratory Conditions</b>	<input type="checkbox"/>	<b>Any other information your treating practitioner should be aware of?</b>	
<b>Pacemaker</b>	<input type="checkbox"/>		
<b>Heart Arrhythmia</b>	<input type="checkbox"/>		
<b>Diabetes</b>	<input type="checkbox"/>		
<b>Cancer</b>	<input type="checkbox"/>		_____
<b>For Women</b>			_____
Pregnant?	<input type="checkbox"/>		_____
Number of weeks _____			
Due Date _____			

**Exercise Activity**  
(Type & Frequency)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*\*Patient's Initials** \_\_\_\_\_

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.**  
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Toronto, ON  
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