PHYSIO IN THE SIX

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 (BEFORE HST)
30 minutes – Registered Massage Therapy	**$ 60.00**
45 minutes – Registered Massage Therapy	**$ 75.00**
60 minutes – Registered Massage Therapy	**$ 90.00**
75 minutes – Registered Massage Therapy	**$ 105.00**
90 minutes – Registered Massage Therapy	**$ 120.00**

N.B. Fees are subject to change. 01/09/2017

As per regulations set by the Canadian Government, HST is required to be added on to all Registered Massage Therapy charges.

****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.

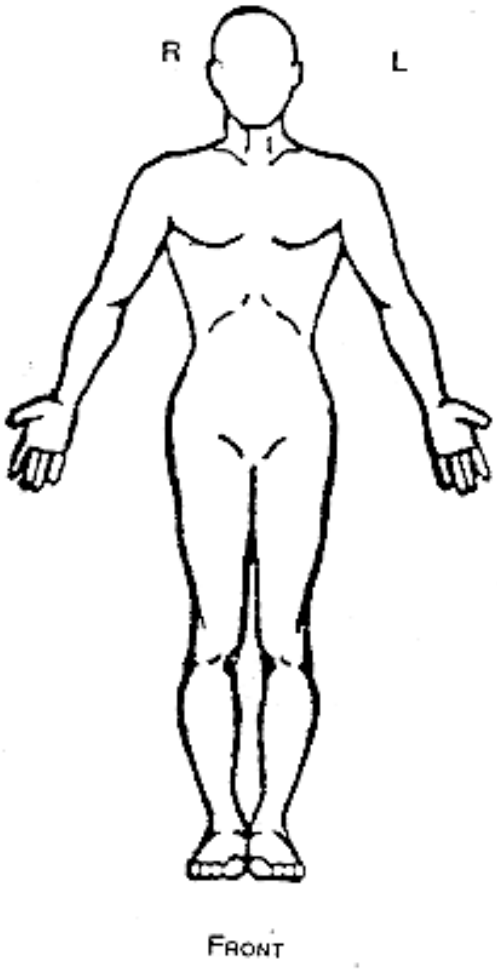
Signature_____ **Date (*dd/mm/yyyy*)** ____/____/_____

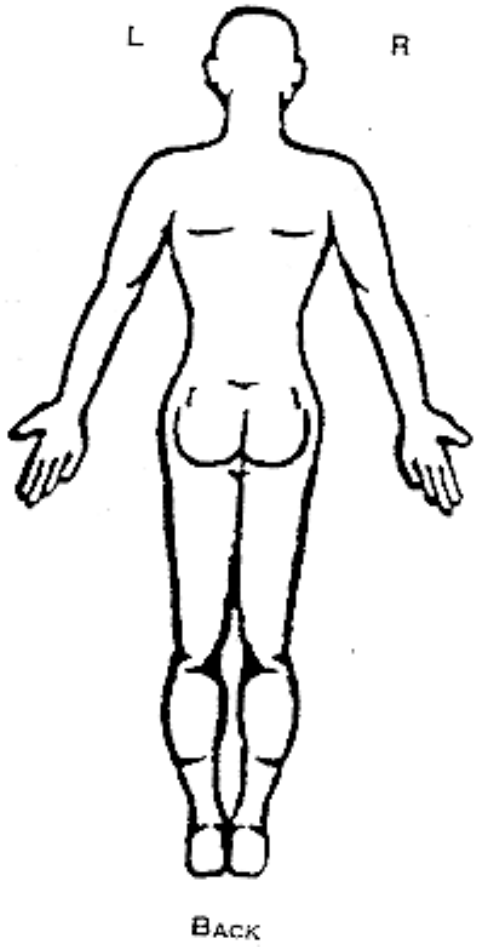
Physio In The Six Inc.
Symptom Diagram

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.
REVIEW OF SYSTEMS - CONFIDENTIAL HEALTH PROFILE

Name:_____

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

If you are having difficulty with any of the following, please complete by checking the boxes that apply to you

GENERAL

- Insomnia ❑
- Fatigue ❑
- Weight loss ❑
- Weight gain ❑

HEAD

- Headache ❑
- Dizziness ❑
- Head trauma ❑
- Fainting ❑
- Blacking out ❑

EYES

- Itching/redness ❑
- Change in vision ❑
- Cataracts ❑
- Light sensitivity ❑
- Flashes in vision ❑
- Spots in vision ❑
- Glaucoma ❑

EARS

- Ringing/tinnitus ❑
- Impaired hearing ❑
- Earache ❑
- Dizziness ❑
- Discharge ❑

MOUTH & THROAT

- Bleeding gums ❑
- Cold sores ❑
- Sore throat ❑
- Jaw/TMJ Problems ❑
- Hoarseness ❑
- Swollen glands ❑
- Goiter ❑

NOSE

- Hayfever ❑
- Loss of smell ❑
- Nosebleeds ❑
- Sinus Problems ❑

LUNGS

- Difficulty breathing ❑
- Shortness of breath ❑
- Persistent cough ❑
- Coughing phlegm ❑
- Coughing blood ❑
- Asthma ❑
- Pneumonia ❑
- Emphysema ❑
- Bronchitis ❑
- Infections ❑

VASCULAR

- Angina ❑
- Murmurs ❑
- Heart disease ❑
- Chest pain ❑
- Palpitations ❑
- Ankle swelling ❑
- Cold feet/hands ❑
- Leg cramps ❑
- Calf pain ❑
- Varicose veins ❑
- Low/high blood pressure ❑

GASTROINTESTINAL

- Bloating/gas ❑
- Heartburn ❑
- Ulcers ❑
- Liver disease ❑
- Gall bladder disease ❑
- Vomiting/nausea ❑
- Abdominal pain ❑
- Diarrhea ❑
- Constipation ❑
- Blood in stool ❑
- Hemorrhoids ❑
- Hernias ❑

SKIN

- Rash ❑
- Itching/hives ❑
- Changes in moles ❑
- Psoriasis ❑
- Eczema ❑

URINARY

- Difficulty urinating ❑
- Pain urinating ❑
- Blood in urine ❑
- Bed-wetting ❑
- Urinary urgency ❑
- Frequent urination ❑
- Frequent infections ❑
- Kidney stones ❑

NEUROLOGICAL

- Seizures/epilepsy ❑
- Strokes ❑
- Tingling sensation ❑
- Muscle weakness ❑
- Difficulty walking ❑
- Poor coordination ❑
- Paralysis ❑
- Speech problems ❑
- Loss of memory ❑

MUSCLE & BONE

- Joint pain ❑
- Stiffness ❑
- Muscle ache ❑
- Arthritis ❑
- Fractures ❑
- Dislocations ❑

ENDOCRINE

- Diabetes ❑
- Hypoglycemia ❑
- Hormone therapy ❑
- Thyroid problems ❑
- Heat/cold intolerance ❑
- Night sweats ❑

EMOTIONAL

- Depression ❑
- Mood swings ❑
- Anxiety/nervousness ❑
- Tension ❑
- Phobias ❑
- Alcohol/drug abuse ❑

CONDITIONS

- AIDS/HIV ❑
- Eating disorders ❑
- Rheumatic arthritis ❑
- Rheumatic arthritis ❑
- Rheumatic fever ❑
- Alcoholism ❑
- Cancer/tumor ❑
- Polio ❑
- Parkinson's ❑
- Multiple sclerosis ❑
- Gout ❑
- Anemia ❑
- Osteoporosis ❑
- High cholesterol ❑
- Fibromyalgia ❑
- Chronic fatigue ❑
- Hepatitis ❑
- Migraines ❑

Physio In The Six Inc.
CONFIDENTIAL HEALTH PROFILE CONTINUED

Name:_____

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

Please complete by checking boxes that apply to you

Injury Affecting Sleep Yes ❑ No ❑

Do you smoke? Yes ❑ No ❑

If yes, how many per day? _____

If yes, how long? _____

Have you had previous care from:

Physiotherapist ❑
Massage therapist ❑
Chiropractor ❑
Naturopath ❑

For Women

Are you pregnant? Yes ❑ No ❑

Number of weeks_____

Due Date_____

Do you have children? Yes ❑ No ❑

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 Inc.

REGISTERED MASSAGE THERAPY CONSENT TO TREATMENT

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

I understand that treatment may include treatments for therapeutic, preventative, palliative, diagnostic, cosmetic, or other health related purposes. I further understand that there are some very slight risks to treatment, including but not limited to muscle tenderness, stiffness, and sometimes slight bruising. Although some treatments may be painful, every effort is made to minimize the discomfort. Treatment can be ceased or modified at any time upon request.

In regards to the removal of clothing, only in the areas to be treated, is the removal of certain clothing preferred for effective treatment. I have the right to decline the removal of certain or any clothing. If I wish, I have the option of bringing and wearing shorts and bra (for women) during the treatment.

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

I 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 registered massage therapy assessment and entire course of treatment.

_____ _____

Patient's Name (*Please print*) Massage Therapist'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
M8V 1J3