Killens Reid
Physiotherapy Clinic
Your health is in good hands
130 Albert St., Suite 610 Ottawa, ON K1P 5G4
(613) 594-8512 www.killensreid.com

New Client Information

Please let us know how you heard about our clinic: _____

Name: _____

Date: _____ DOB (mm/dd/year): _____

Address: _____

City: _____ Postal Code: _____

Tel # (home): _____ Tel # (work): _____ Tel # (cell): _____

Email: _____

Physician: _____

Address: _____

City: _____ Postal Code: _____

Physician's tel#: _____ Physician's fax #: _____

Please list all MEDICATIONS and SUPPLEMENTS:

_____

_____

_____

_____

_____

_____

_____

_____

CANCELLATION POLICY:
Same day cancellations are subject to 50% of the session fee.
No Notification or <2 hours notice are subject to 100% of the session fee.

Health Inventory
(please check only those that apply to you)

If YES to any of the below, please explain and give approximate dates:

☐ Diabetes	☐ Osteoporosis/Osteopenia
☐ High Blood Pressure	☐ Osteoarthritis
☐ Heart Disease	☐ Other Arthritis
☐ Heart Attack	☐ Fractures
☐ Pacemaker	☐ Metal Implants
☐ Hypothyroidism	☐ Hyperthyroidism
☐ Surgeries	☐ Hernia
☐ Respiratory Disorders	☐ Neurological Disorders
☐ Allergies to Cold	☐ Allergies to Heat
☐ Allergies to Metal	☐ Other Allergies
☐ Depression/Anxiety	☐ Epilepsy/Seizures
☐ Glaucoma	☐ Current Pregnancy
☐ Cancer	☐ Hepatitis A/B
☐ Headaches	☐ Smoker
☐ Dizziness/Vertigo	

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INFORMED CONSENT

DATE OF INJURY: _____

I understand that the Initial Assessment will include a verbal case history and physical examination. I understand that after receiving my Initial Assessment, I will be given the information on what would be the most appropriate treatment for my condition, as well as alternative courses of action, risks and potential side effects of treatment.

I understand that my information will be protected and never released to a third party without my consent. Only pertinent information regarding my health and medical condition will be collected. Storage, retention and destruction of my personal information will comply with existing Ontario provincial legislation and privacy protection protocols as set out by the professional regulatory bodies (College of Physiotherapists of Ontario, College of Massage Therapists of Ontario, Ontario Association of Osteopaths).

The privacy policy is available to read upon request. I understand that I may withdraw consent at any time without prejudice to me. I understand that if I have questions pertaining to this information, I may contact the Killens Reid Physiotherapy Clinic.

The client, the witness, or any party executing this consent on behalf of the client, is at least 18 years of age. The client fully understands this consent. The laws of the province of Ontario shall govern this consent;

I have read and understood the contents of this consent.

Name (print): _____ Date: _____

Signature: _____ Parent/Guardian: _____

CONSENT FOR RELEASE OF INFORMATION

I, _____, the undersigned, freely and voluntarily consent to the release of all pertinent medical information to the Killens Reid Physiotherapy clinic by:

- Referring Physician
- Lawyer
- Insurance Company
- Allied Health Professional (e.g. RMT, chiropractor, osteopath, NP, etc...)
- Other:_____

I also consent to the release of relevant medical information, including:

- X-Rays
- CT Scan
- MRI
- Diagnostic Ultrasound
- Bone Density report
- Other:_____

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