



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: _____ Country: _____ Postal Code: _____

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

Email: _____

Physician: _____

Address: _____

City: _____ Country: _____ 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 <24 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:

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

CANCELLATION POLICY:

Same day cancellations are subject to 50% of the session fee.
No Notification or <24 hours notice are subject to 100% of the session fee.

INFORMED CONSENT AND CONSENT FOR RELEASE OF INFORMATION

Date of Injury/MVA:

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

- Referring Physician
- Employer
- Lawyer
- Insurance Company
- Massage therapist
- Other: _____

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

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

I understand that this information will be used by my treating professional at the Killens Reid Physiotherapy Clinic, in order to properly assess my medical status and to develop an appropriate rehabilitation program.

I understand that I may withdraw consent at any time without prejudice to me.

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 if I have any questions pertaining to the above information, I may contact the Killens Reid Physiotherapy Clinic

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 Physiotherapist of Ontario, College of Massage Therapists of Ontario, Ontario Association of Osteopaths).

The privacy policy is available to read upon request.

The client, the witness, or any party executing this release on behalf of the client, is at least 18 years of age. The client fully understands this release. The laws of the province of Ontario shall govern this release; I have read and understood the contents of this release.

Name: _____

Date: _____

CANCELLATION POLICY:

Same day cancellations are subject to 50% of the session fee.
No Notification or <24 hours notice are subject to 100% of the session fee.