



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:

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**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:

|  |  |
|--|--|
| <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     |  |

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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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I have read and understood the contents of this release.

Name (print): \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Parent/Guardian: \_\_\_\_\_

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