Clayton Heights Sports & Therapy Center
105-18640 Fraser Hwy
Surrey, BC
V3S 7Y4

P: 604-579-0105
E: info@claytonheightsphysio.com

Confidential Patient History Form

Name: _____

Are you currently working?
▢ Yes ▢ No

Referring Professional (if applicable): _____

Occupation: _____

Work Duties (Describe): _____

Please indicate if you believe any of the following apply to you currently or in your past:

Head/Neck
▢ Headaches
Frequency:
_____
▢ Migraines
Frequency:
_____
▢ Head Injury
▢ Concussion
▢ Jaw/TMJ
▢ Whiplash
▢ Vision
▢ Ear Problems
▢ Fainting
▢ Sinus
▢ Facial Pain
Other Neurological Issues:
_____

Cardiovascular
▢ High Blood Pressure
▢ Low Blood Pressure
▢ Chronic Congestive Heart Failure
▢ Heart Attack
Heart Attack Date:
_____
▢ Stroke
Stroke Date:
_____
▢ Cardiovascular Aneurysm
Cardiovascular Aneurysm Date:
_____
▢ Pacemaker/Other Device

Birth & Childhood
▢ Birth Trauma
▢ Feeding Problems
▢ Colic
▢ Recurrent Ear Infections
▢ Developmental Delays
▢ Behavioural
▢ Restlessness
▢ ADD/ADHD
▢ Learning Problems
▢ Eye Motor Problems
▢ PDD/Autism

Other Conditions
▢ Osteoporosis
▢ HIV
▢ TB
▢ Skin Conditions
▢ Hepatitis
▢ Diabetes
▢ Epilepsy/Seizures
▢ Cancer
▢ Arthritis
▢ Fatigue
▢ Numbness/Tingling
▢ Hyper/Hypo Thyroid
Are You Pregnant?
▢ Yes ▢ No
Due Date If *Yes*:
_____
Are you trying to get pregnant?:
▢ Yes ▢ No

Respiratory
▢ Chronic Conditions
▢ Shortness of Breath
▢ Bronchitis
▢ Asthma
▢ Emphysema

Gastrointestinal
▢ Heartburn
▢ Nausea
▢ Constipation
▢ Hemorrhoids
▢ Diarrhea
▢ Ulcers
▢ Irritable Bowel Syndrome
▢ Colitis
▢ UTI/Bladder Infections
▢ Other Urinary Conditions

Physical
▢ Joint Dislocation
▢ Bone Fracture
▢ Rods/Pins/Plates/Shunts
Implant(S):
_____
Transplant(S):
_____
▢ Corrective Lenses/Contacts
▢ Spinal Injury
▢ Varicose Veins

Please List Any Medications You Presently Take:

Known Allergies (Including Medications, Foods, Seasonal Oils and Lotions, Etc.):

Are You A Smoker?: ▢ Yes ▢ No ▢ Occasional
Alcohol Consumption: ▢ None ▢ Light ▢ Moderate ▢ Heavy
Do You Have A Family History of Medical Conditions?: ▢ Yes ▢ No
Please List If *Yes*:

Do You Live with A Smoker?: ▢ Yes ▢ No
Dominant Hand: ▢ Left ▢ Right

Have you ever been hospitalized, or had any major accidents, or illnesses?: ▢ Yes ▢ No
Describe If *Yes*:

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List any non-prescription vitamins, minerals, or other supplements you are taking:

List all surgeries (including abdominal) and year of surgery:

List any activities, sports, or hobbies that you participate in regularly:

Please Circle the Answer Closest to How You Presently Feel (1= Poor, 5 = Excellent):

Quality of Sleep	1	2	3	4	5	Hours of Sleep Per Night (Approx.)
Energy Level	1	2	3	4	5	
Eating Habits	1	2	3	4	5	(Number of Meals Per Day That You Eat)
Stress Level	1	2	3	4	5	Number of Times You Exercise Per Week? _____

Reason for Today's Visit (What Would You Like Worked On)

Please describe your current condition & symptoms:

How long have you had this condition?

How did it start?

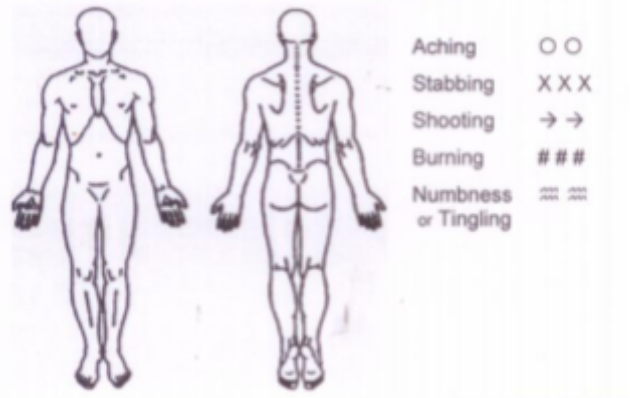
Is it getting better, worse or the same? ▢ Better ▢ Worse ▢ Same
What aggravates it? (i.e., Certain Movements, Sleeping)

What relieves it? (position, heat, ice, medications)

Have you had a problem like this before? ▢ Yes ▢ No
If *Yes,* When?

How was it treated?
▢ Massage Therapy ▢ Chiropractor
▢ Physiotherapy ▢ Acupuncture
▢ Naturopath ▢ Other: _____
was it resolved?: ▢ Yes ▢ No
Have you had any X-Rays/MRI/CT scans etc.?
▢ Yes ▢ No
If yes, when?

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:



Pain Scale Rating:_____
(Pain Scale 1-10, 1= None, 10= "I need to go to the hospital")

Since the condition started have there been any changes to the bladder or bowel?: ▢ Yes ▢ No
Are You Suffering from Dizziness? ▢ Yes ▢ No
How often, if *yes?*

I authorize the clinic and its associated practitioners to collect my personal and medical information as documented above in order to access, diagnose, and develop a treatment plan and provide treatment. I authorize the clinic and its associated practitioners to communicate with my referring md as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature: _____ Date: _____

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Full Name: _____

Preferred Name: _____

Email: _____

Home Phone: _____

Mobile Phone: _____

Birth Date (Month/Day/Year): _____

Personal Health Number _____

Family Doctor: _____

Family Doctor Phone: _____

Parent/Guardian: _____

Street Address: _____

Suite Number: _____

City: _____

Province: _____

Country: _____

Postal Code: _____

Gender: _____

Sex: _____

Occupation: _____

Employer: _____

Patient Consent
By signing below, I consent to treatment. During the initial assessment, I will be assessed and a treatment plan will be discussed and explained. I can ask questions and have the right to be informed of the treatment provided. I may stop treatment at any time.

☐ I have read the posted fees and agree to pay those fees for treatment. I understand that payment for all treatment, whether private or insured, is ultimately the responsibility of the patient. It is the patients' responsibility to keep track of their claim status and the number of visits that have been approved. In order to receive the insurer rates, the clinic must confirm that you are approved for coverage directly from the insurer. any fees not covered or refused from any third party or insurer is immediately due to the clinic at the private rates posted above. I understand that any outstanding balances are due before I may start my next treatment.

☐ I accept the terms and conditions

Extended Benefits Assignment
I hereby assign benefits payable for the eligible claims to the healthcare provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to such provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the healthcare provider for any services rendered and/ or supplies provided. I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this benefit assignment form, that any benefit payment made in accordance with this benefit assignment form will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment. I understand that this assignment will apply to all eligible claims submitted electronically by my healthcare provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator. If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the healthcare provider.

☐ I accept the terms and conditions

Cancellation/No Show Policy:
Your appointment time has been reserved for you. In courtesy of your therapist and fellow patients, we ask that you provide us with 24 hours' notice of cancellation, or a cancellation fee will be charged. If you are late for your scheduled appointment please be advised that your appointment will end at the time it was originally booked for and the price of the original duration will be charged. there is an option to choose to receive a reminder by email or text message. This reminder is a courtesy reminder for an appointment and time slot already pre-scheduled. In no way by not receiving a reminder shall the cancellation policy be void.

☐ I accept the terms and conditions

LATE CANCELLATION/MISSED APPOINTMENT CHARGES ARE THE FULL AMOUNT OF THE ORIGINAL APPOINTMENT. 24 HOURS' NOTICE IS REQUIRED TO CANCEL AN APPOINTMENT.

☐ I accept the terms and conditions

Signature: _____ Date: _____

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Extended Health Plans

- We are able to bill most extended health plans. This includes: Blue Cross, Canada Life, Chambers Of Commerce, Claim Secure, Desjardins, Empire Life, Equitable Life, Green Shield, Group Health, Group Source, Industrial Alliance, Johnston, Manion, Manulife, Maximum Benefit, Medavie, SSQ Insurance, and Sunlife.
- Every extended health plan is different. Each company chooses the coverage that they provide to their employees. If your insurer is not on the list, the fees are payable at the private rate and it is the patient's responsibility to submit them to the insurance company. It is the patient's responsibility to know the coverage and limitations of their extended health plan.
- We can only directly bill the amount that is provided by the insurance company, any balances not covered will need to be paid at the time of your visit, and then manually submitted to your carrier by you.

Please bring your card in with you on your first visit.

Authorization and Consent to Bill Your Extended Benefits:

- ☐ I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.
- ☐ I authorize such insurer and/or plan administrator and their service provider(s) to:
- Use my personal information for the above purposes.
- Exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, administrators of government benefits, or other benefits programs, other organizations, or service Providers working with such insurer and/or plan administrator or any of the foregoing, when relevant for the above purposes.
- Where applicable exchange personal information concerning any claims with any assignee of benefits payable and exchange personal information for the above purposes electronically or in any other manner.
- ☐ I understand that personal information may be subject to disclosure to those authorized under applicable law.
- ☐ I agree that a photocopy or electronic version of this authorization shall be as valid as the original and may remain in effect for the continued administration of the group benefits plan.
- ☐ In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning any claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable my employer or benefit plan sponsor, for the purposes of investigation and prevention of fraud and/or benefit plan abuse. I understand that the submission of fraudulent claims is a criminal offence. If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my benefit plan sponsor, for that purpose. If the patient is a person other than myself, I confirm that the patient has given their consent to provide their personal information for the healthcare provider and the insurer and/or plan administrator and their service provider(s) to use and disclose their personal information as set out above.

Insurance Plan Name:

_____

ID/Claim/Employee Number:

_____

Policy/Group/Plan Number:

_____

ICBC

Claim #:

_____

New ICBC clients are entitled to 25 physiotherapy, 25 chiropractic, 12 RMT, 12 acupuncture and 12 active rehab sessions, within 12 weeks of the accident date. After 12 weeks, a new referral and confirmation of coverage is required.

RCMP/DVA

ID#: R_____

Your plan covers an annual total of $4800 in combined services. Chiropractic, physiotherapy, massage, and acupuncture are all services covered. A referral from your doctor is required for all RMT visits and must be brought into the clinic. Each referral is valid for one year from the date on the referral.

MSP

Patients who qualify for premium assistance through the BC medical plan are entitled to 10 visits total per calendar year including physiotherapy/ chiropractor/podiatry/naturopath and massage. Any fees over the limit or refused by MSP are payable immediately to the clinic at the private rate. Patients can call medical services to see if they are entitled to premium assistance.

By signing below, I have read and understood Clayton Heights Sports and Therapy Center's patient consent, benefits authorization, and cancellation policy and agree to its terms.

Signature: _____ Date: _____