SUMMIT
PHYSIOTHERAPY

NEW PATIENT FORM

1 WHAT IS THE MAIN ISSUE OR REASON THAT BROUGHT YOU HERE?

2 ARE YOU LOOKING FOR A SPECIFIC TYPE OF TREATMENT?
(Acupuncture, Cranio-Sacral Therapy, IMS, Home Exercise, etc.)

3 HOW DID YOU HEAR ABOUT SUMMIT PHYSIOTHERAPY?
(Doctor, friend or family referral, google/internet search, phone books, signs)

4 NAME OF PHYSICIAN:

5 LOCATION AND/OR PHONE NUMBER OF PHYSICIAN?

6 ARE YOU RECEIVING CHIROPRACTIC, MASSAGE, PHYSIOTHERAPY FOR THIS OR ANY OTHER CONDITION? Y/N

7 ARE YOU MAKING A CLAIM THROUGH WCB (WORKERS COMPENSATION BOARD)? Y/N
IF YES, PLEASE NOTIFY RECEPTION.

8 ARE YOU COVERED THROUGH AN EMPLOYEE BENEFITS PLAN OR PRIVATE HEALTH CARE? Y/N
(Alberta Bluecross, Manulife, etc.)?

9 IS YOUR CONDITION RELATED TO A MOTOR VEHICLE ACCIDENT? IF YES, PLEASE LET US KNOW. Y/N
ACCIDENT DATE:

10 ARE YOU PREGNANT? IF YES, DUE DATE: Y/N

11 WHAT IS YOUR OCCUPATION?

12 EMERGENCY CONTACT INFORMATION
NAME:

RELATIONSHIP:

PHONE NUMBER:

13 ARE YOU TAKING ANY MEDICATIONS? IF YES, NAMES OF THE MEDICATION Y/N
(or purposes for use, like, high blood pressure medication).

Continue to Other Side

PAST HISTORY

14 DO YOU HAVE ANY DIAGNOSED MEDICAL CONDITIONS? Y/N
(Hepatitis, HIV, Asthma, Diabetes, etc.) PLEASE LIST:

15 HAVE YOU HAD ANY SURGERY (for any reason)? PLEASE LIST: Y/N

16 HAVE YOU HAD ANY STEROID TREATMENT? (i.e. Prednisone or cortisone injections) PLEASE LIST: Y/N

17 DO YOU HAVE ANY METAL IMPLANTS (PINS, PLATES, STAPLES)? Y/N

18 DO YOU HAVE AN IMPLANT CARDIAC DEFIBRILLATOR / NEUROSTIMULATOR / PACEMAKER? Y/N

CONSENT

OUR FEE FOR SERVICE IS:

PHYSIOTHERAPY ASSESSMENT (Treatment is included)
$115.00/per visit
$100.00 Seniors (65 years +)

PHYSIOTHERAPY FOLLOW UP VISITS
$85.00/per visit
$80.00 Seniors (65 years +)

MASSAGE THERAPY
$60.00 per 30 minutes / $95.00 per 60 minutes / $135.00 for 90 minutes

CRANIOSACRAL THERAPY
Please call for more information

CUPPING
Please call for more information

The Community Rehabilitation program (CRP) parameters will be explained to you by our receptionist.

The therapist will explain your specific treatment procedures. If you have any questions or concerns, please do not hesitate to ask.

As confirmation that you understand and acknowledge the above information, please consent to treatment by signing below.

PRINT NAME

PATIENT OR PARENT/GUARDIAN SIGNATURE

DATE

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