Treloar Physiotherapy Clinic

NEW CLIENT INTAKE FORM

595 West 8th Avenue
Vancouver, BC V5Z 0C4
Phone: 604.875.6207
Fax: 604.875.6208

Date:
Last Name:
First Name:
Home Phone:
Cell Phone: Work Phone:
Email Address:
Please notify me via email for: ☐ my upcoming appointments ☐ clinic updates/promotions ☐ clinic newsletter
Street Address:
City Province: Postal Code:
Birth date: Year Month Day
Gender: ☐ M ☐ F ☐ Other:
Occupation:

Carecard #(required for Work Safe and ICBC claims):
Family Doctor Name (first & last name):
Address:
Phone Number:
Can we have permission to send a short First Visit Report to your Doctor? We will identify the area we are treating and outline our treatment plans: ☐ Yes ☐ No

What area of the body or injury will we be assessing today?
Please list any treatments currently or previously used for this condition and their results:
Is today's visit part of a **WorkSafeBC Claim**? ☐ Yes ☐ No Is today's visit part of an **ICBC Claim**? ☐ Yes ☐ No ***IF YES**, please see reception for mandatory additional paperwork relating to your claim*

How did you hear about Treloar Physiotherapy Clinic?	
□ Family Doctor:	□ Specialist/Referring Doctor: Name:
□ Physiotherapist Name:	□ Therapist (Massage/OT/etc..) Name/Type:
□ Friend/Family Member: Name:	□ Other (please specify):

CLIENT CONSENT

Personal Information

Protecting your privacy and personal information is an important part of Treloar Physiotherapy Clinic's policies and procedures. We strive to provide quality care and we collect, use, disclose, retain and dispose of your personal information in compliance with federal and provincial privacy legislation and applicable college regulations. We will try to be as open and transparent as possible about the way we handle your personal information.

Treatment

I hereby give my consent to undergo treatment at Treloar Physiotherapy Clinic. Where appropriate, my treatment may include manual therapy, modalities (e.g. heat, ice, laser, ultrasound, interferential current (IFC), electrical muscle stimulation, TENS, mechanical traction, acupuncture, dry needling, intramuscular stimulation), and active exercise (e.g. Pilates, strength-training, cardiovascular exercise). If deemed appropriate by my therapist, I agree to have a kinesiologist or support personnel carry out my treatment plan under supervision.

Cancellation Policy

All appointments cancelled within 24 hours notice are subject to a cancellation fee totaling 100% of the cost of the scheduled service.

For Monday appointments, please cancel by 3:00pm Saturday

I do hereby intend to be legally bound for myself, and I waive and release any and all claims for damages I may have against "Treloar Physiotherapy Clinic", it's staff or affiliates for any and all injuries suffered while engaging in the treatment provided to me, and agree to hold "Treloar Physiotherapy Clinic", harmless and indemnify it for any incident(s) arising from my use of "Treloar Physiotherapy Clinic" facilities.

By signing below, I acknowledge that I have reviewed and understand the above information.

Signature: _____ Date: _____

Print Name: _____

EMERGENCY CONTACT

In the event of an emergency, please contact:

Name: _____ Relationship: _____

Phone: _____

Email: _____