BODYNAMICS PHYSIOTHERAPY

YOUR GREATEST WEALTH IS YOUR HEALTH

Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____ Male/Female BC Care Card No.: _____
(M / D / Y)

Address: _____
(Street Address) (City) (Postal Code)

Phone: _____ _____ _____
(Home) (Work) (Cell)

Email: _____

☐ Yes, I consent to receive e-mails

☐ No, please do not send me e-mails

Emergency Contact Name: _____ Number: _____

Family Physician: _____ Referring Physician (if different): _____

How did you hear about our clinic? (Tick)

☐ Patient (Name: _____)
☐ Doctor (Name: _____)
☐ Website
☐ Facebook
☐ Google Ad
☐ Other (please specify: _____)

Is this visit part of:

An **ICBC** claim? Y / N

A **military or DVA** claim? Y / N

A **Worksafe BC** claim? Y / N

Do you have **Premium Assistance** on your MSP? Y / N

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Client Name: _____ Current Date: _____

Occupation: _____

Sports and Interests

_____

_____

Client Health History

What is the reason for your visit?

_____

_____

Related or other problems:

_____

_____

Are you receiving any treatment for the above condition at this time? ☐ Yes ☐ No

What type(s)? _____

Have you received any treatment in the past for this? ☐ Yes ☐ No

What type(s)? _____ Where? _____

Are you taking any medications or remedies? ☐ Yes ☐ No

Names? _____

Have you had any investigations for this matter? (X-rays etc.) ☐ Yes ☐ No

Have you had any motor vehicle accidents, fractures or injuries in the past?

_____

_____

Past surgeries? (Nature and dates)

_____

_____

Please indicate conditions presently causing problems, as well as conditions which were a problem in the past.

	Present	Past
Birth & Children		
Birth Trauma		
Feeding Problems		
Colic		
Recurrent ear infections		
Developmental delays		
Behavioural restlessness		
Sleep problems		
Hyperactivity/ADD/ADHD		
Learning problems		
Eye motor problems		
PDD/Autism		
Respiratory		
Chronic conditions		
Shortness of breath		
Bronchitis		
Asthma		
Emphysema		
Cardiovascular		
High blood pressure		
Low blood pressure		
Congestive heart failure		
Heart attack Date:		
Heart disease		
Phlebitis		
Stroke Date:		
Cardiovascular aneurysm Date:		
Pacemaker/other device		
Coldness in extremities		
Varicose veins		
Arteriosclerosis		
Gastrointestinal		
Heartburn		
Pain before eating		
Discomfort after eating		
Nausea		
Constipation		
Hemorrhoids		
Diarrhea		
Ulcer		

	Present	Past
Head/Neck		
Headaches		
Migraines		
Jaw problems		
(pain/clicking/locking)		
Whiplash		
Vision problems		
Ear problems		
Fainting		
Dizziness		
Ringing in the ears		
Sinus problems		
Facial pain		
Closed head injury		
Other neurological conditions		
Other Conditions		
Osteoporosis		
Immune deficiency		
TB		
Skin conditions		
Hepatitis		
Diabetes Onset:		
Epilepsy/seizures		
Cancer		
Arthritis		
Susceptible to colds/infections		
High stress levels		
Insomnia		
Fatigue		
Nervousness		
Numbness and/or tingling		
Anxiety		
Depression		
Thyroid	Hyper	Hypo
Gynecological conerns		

Is there any other information your therapist should know?

Please initial below to indicate you have read this page to completion:

On-Site Therapy Fee Schedule

Type	Session	Price
Initial Visit	60 minutes	$180 CAD
Follow-Up Visit	60 minutes	$160 CAD per Visit
Follow-Up Visit	45 minutes	$120 CAD per Visit
Follow-Up Visit	30 minutes	$80 CAD per Visit

Tele-Health / Tele-Rehabilitation Fee Schedule

Type	Session	Price
Initial Visit	60 minutes	$120 CAD
Follow-Up Visit	45 minutes	$90 CAD per Session
Follow-Up Visit	30 minutes	$60 CAD per Session
Follow-Up Visit	15 minutes	$30 CAD per Session

Payment to the clinic for all appointments and missed appointments are the responsibility of the client at each visit. The full visit fee will be charged for missed appointments and appointments cancelled with less than 24 hours.

I authorize Physiotherapy Clinic/ Physiotherapists to exchange relevant information regarding my medical care with any member of my health care team.

☐ Yes ☐ No

I have read and understand the above information:

Signature of Patient/Guardian: _____

Date: _____