WELCOME TO COMPLETE WELLNESS CLINIC

Take the first step to wellness!

Your first appointment involves an assessment by a Registered Physiotherapist. Please read our website for more information.

You may be asked to wear a gown or shorts in order to allow the physiotherapist to view the area to be treated. For subsequent visits, it is important to wear comfortable clothing so that you can fully participate. At **Complete Wellness Clinic**, education is a crucial part of our treatment philosophy. We encourage questions so please do not hesitate to voice or email (milton@complete-wellness.ca) any concerns or comments you may have to your physiotherapist.

OUR FEES

Type of Appointment	Pelvic Health Physiotherapy	MSK Physiotherapy
Initial Assessment	$110	$90
Subsequent Visit	$90	$60

Please read the following procedures carefully, prior to consenting to treatment.

- **Complete Wellness Clinic** is a private chiropractor owned clinic and as a result **we do not have OHIP billing privileges.** Physiotherapy treatment may be covered by either extended health insurance plans through your employment, motor vehicle accident insurance from a car accident or WSIB if your injury is work related. Please let us know which method upon first assessment. Please be sure to check into the details of your coverage since every plan is different, and it is the client's responsibility to understand any limitations to your coverage
- **Complete Wellness Clinic** requires **payment at the time services are rendered**. Payment can be made by cash, cheque, debit, Visa/MC.
- If you cannot attend an appointment, please give **24 HOURS NOTICE** so that another patient may receive care during that time. If you cannot cancel with 24 hours' notice, you will be billed for untimely or missed appointments.
- In order to receive the best medical care from all providers, we would ask that you notify your physiotherapist if you have an upcoming doctor's appointment so that a progress note can be forwarded to your doctor. Also, please notify your physiotherapist of any related investigations that have been done so copies can be obtained if necessary.

I have read and give my consent to the above specifications.

_____	_____	_____
Client's signature	**Name (please print)**	**Date**
_____	_____	
Parent/Guardian signature	**Parent/Guardian Name (Please Print)**	

Signature of Parent/Guardian consenting to assume financial responsibility if client is under age 18

Complete Wellness Clinic
milton@complete-wellness.ca
450 Bronte St. S, Milton ON, L9T 8T2
Tel: (905) 875-2288

PERMISSION TO DISCLOSE HEALTH INFORMATION

Name:(PLEASE PRINT) _____

Date of Birth: (YYYY/MM/DD)_____

Address: _____

Town: _____

Postal Code: _____

Phone: _____

Authorization and consent for release of information to my physiotherapist.

Disclosing Professional(s) Name: _____
(Family Doctor's Name)

- ❑ Diagnostic Reports (X-RAYS, ultrasounds, MRI, CT/Bone Scan)
- ❑ Clinical Reports
- ❑ Surgical Reports
- ❑ Operative Protocols

I authorize the disclosure of the above-identified information regarding my injury

Signature: _____

Date: _____

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CONFIDENTIAL PATIENT INFORMATION SHEET

NP # _____
OFFICE USE ONLY

Please complete FULLY and accurately.

PERSONAL HISTORY

Name	
Date of birth (YYYY/MM/DD)	
Sex	□ Male □ Female
Address	Street: _____ City: _____ Postal Code: _____
Telephone	
Email Address	
Family Doctor	
Emergency Contact	Name: Telephone: Relationship:
Email Address	
How were you referred to this clinic?	□ Massage Therapist □ Naturopathic Doctor □ Friend/Family □ Health/Injury Talk □ Advertising/Pamphlet □ Other (please specify)

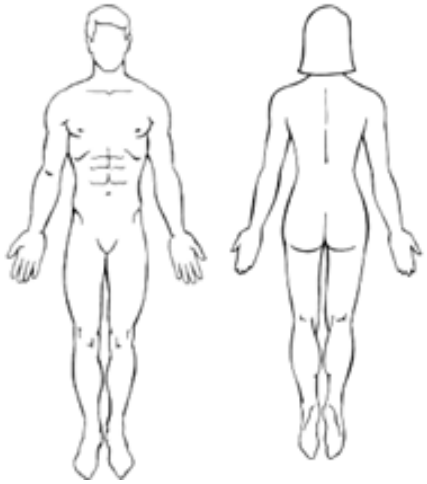
Is this a **Workplace Safety and Insurance Board (WSIB)** injury? □ Yes □ No
Are your injuries related to a **Motor Vehicle Accident (MVA)** case? □ Yes □ No

CURRENT HEALTH HISTORY

Current complaint(s):

_____
_____
_____

On the drawings to the right, mark all painful areas with an **X**.



Describe the pain:

□ Sharp & stabbing □ Burning
□ Pins & needles □ Dull, achy
□ Numb □ Stiff, tight

Circle your level of **Pain/discomfort**
(0 = no pain, 10 = worst pain)

0 1 2 3 4 5 6 7 8 9 10

How long have you had this injury/pain? _____
Have you had this injury/pain before? □ Yes □ No
Previous physiotherapy care? □ Yes □ No

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CONFIDENTIAL MEDICAL HISTORY

Please check those that apply to you to ensure that we understand any critical areas of your medical history.

Head and Neck
- □ Headaches
- □ Migraines
- □ Glasses

Respiratory
- □ Chronic cough
- □ Shortness of breath
- □ Smoke
- □ Asthma
- □ Breathing problems

Digestive
- □ Difficult digestion
- □ Constipation
- □ Liver/gall bladder
- □ Diabetes
- □ IBS

Cardiovascular
- □ High/low blood pressure
- □ Poor circulation
- □ Heart disease
- □ Phlebitis
- □ Varicose veins

Skin
- □ Bruise easily
- □ Skin conditions

Other
- □ Sinus
- □ Insomnia
- □ Cancer/type
- □ Arthritis/type
- □ Epilepsy
- □ Seizures
- □ Pregnancy
- □ AIDS

Specific medical condition(s):

_____

_____

Have you had any surgeries?

SURGERY TYPE	DATE	ONGOING SYMPTOMS

Current medications:

MEDICATION NAME	REASON FOR MEDICATION

Signature _____ **Date** _____

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