Mike Munro B.Sc. P.T., C.I.Y.I.
Therapeutic Approach Yoga Studio
Physiotherapy Assessment

Last Name: _____ First Name: _____ Initial: _____
Mailing Address: _____
City/Province_____ Postal Code: _____
Day Phone: _____ Eve. Phone: _____
Birth Date: (m) _____ (d) _____ (y) _____ Sex: M F
Referring Doctor: _____Family Doctor: _____
Referring Doctor Address: _____
Date of Injury: _____
Occupation: _____
Place of Employment: _____
Name of School: _____
Guardian Name (if under 18): _____
Relationship to Guardian: _____
Guardian Address: _____
Goals of Treatment:
_____
_____

Physiotherapy Service Information and Consent

On your first visit, the physiotherapist will complete an initial assessment to determine a treatment plan. This assessment will consist of an interview and an examination of your posture and movement (which will include certain test movements). Depending on the length of the assessment, treatment may or may not be initiated on your first visit. A doctor's referral is no longer needed to receive physiotherapy treatment. However, a doctor's note may be required by your insurance company for reimbursement of this service.

Fees:
Fees are payable by Cash, Cheque, Master Card or Visa. Direct Billing is available through Blue Cross and Green Shield, however, a doctor's referral may be required for this service. Please contact your insurance provider for policy details.

Initial Assessment:	**45 minutes – 1 hour: $95**
Treatment:	**1 hour: $95**
	½ hour: $50
	¼ hour: $35
	Group class: $25

A cancellation fee of $25 will be charged for late cancellations(less than 24hours notice), missed appointment will be billed in full.

Consent:
I certify that I agree to be responsible for all fees associated with treatment, and any insurance/ compensation claims that are refused, expired, or otherwise not paid by a third party, will be my responsibility. I authorize that payment approved through direct billing will be sent directly to the practitioner from the insurance provider.
The statements and answers given on this form are accurate to the best of knowledge. I understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

Would you like your medical doctor or referring health care practitioner to receive medical reports? Y___ N___

_____ _____
Patient/Guardian Signature Date

(over)

Medical History

Please list any physical conditions that might limit your participation in physical exercise.

Please list any prescription medication(s) you are currently taking and the related health condition(s).

Please check any of the following that might apply to you:

- ▫ Arthritis
- ▫ Glaucoma
- ▫ Chronic sinuses
- ▫ Low blood pressure
- ▫ Hernia
- ▫ Ulcers
- ▫ Diabetes
- ▫ Hypoglycemia
- ▫ Asthma
- ▫ Epilepsy
- ▫ Heart trouble
- ▫ High blood pressure
- ▫ Pregnant/due date? _____

History of Present Illness:

Is there anything else you feel I need to know about your health history in order to work with you?