PHYSIOOUTAOUAIS

 # File _____

Patient Intake Form

A — Contact Information

We collect the following information to create and manage your file, to contact you regarding your appointments, and to communicate with you or your emergency contact should the situation require it, to the extent necessary for the continuity of your care.

First Name	Last Name	Name at birth	Sex	Language
			☐ M ☐ F ☐ O	☐ Fr ☐ En

Address	City	Province	Postal Code

Home Phone	Work Phone	Cell Phone	Other

Date of Birth (YYYY/MM/DD)	Email

Emergency Contact — Name	Emergency Contact — Phone

B — Occupation & Referral

Your occupation and personal interests help us better understand your daily life and tailor our therapeutic recommendations. Information about how you heard about us is used for internal administrative purposes only and is not shared.

OCCUPATION

☐ Office ☐ Transportation ☐ Construction
☐ Factory ☐ Teacher ☐ Sales
☐ Student ☐ Unemployed ☐ Day Labourer
☐ Prof. Services ☐ Retired

HOW DID YOU HEAR ABOUT US?

☐ Physician ☐ Dentist
☐ Former Patient ☐ Family / Friend
☐ Word of Mouth ☐ Employer
☐ Website ☐ Social Media
☐ Television ☐ Radio
☐ Sign/Billboard

Personal Interests (sports, arts, leisure)

C — Clinical Information

This information helps direct your file to the appropriate coverage plan and document the event requiring your care. Depending on the context of your visit and only if necessary, it may be transmitted to the relevant organizations (CNESST, SAAQ, WSIB, insurer) — strictly within the scope of your file and the services received.

Referring Physician (if applicable)	Health Insurance Number *For communication with your referring physician*

Affected Area of the Body and Reason for Consultation	Date of Incident (YYYY/MM/DD)

FILE CATEGORY

☐ Private ☐ CSST / CNESST ☐ SAAQ ☐ WSIB / CSPAAT ☐ RCMP ☐ DND ☐ Veterans Affairs

Agent Name (if applicable)	Agent Phone	#File CSST / SAAQ / WSIB

Claim Filed: ☐ Yes ☐ No

D — Health Questionnaire

Your physiotherapist needs to know about certain medical conditions to personalize your treatment, avoid contraindications, and adapt the progression of your rehabilitation. Check all that apply and add details as needed.

SECTION A — TREATMENT SAFETY

This information allows us to choose safe and appropriate techniques for your treatment plan.

☐ **Pacemaker**	☐ **Metal Implant**	☐ **Phlebitis / Thrombosis**
☐ **Osteoporosis**	☐ **Seizures / Epilepsy**	☐ **Heart Condition**
☐ **High Blood Pressure**	☐ **Respiratory Issues**	☐ **Dizziness**

SECTION B — TREATMENT PLANNING

This information influences the treatment plan, exercise progression, specific precautions, and referrals to other professionals.

☐ **Surgeries**	☐ **Allergies**	☐ **Cancer**
☐ **Diabetes**	☐ **Rheumatoid Arthritis**	☐ **Thyroid**
☐ **High Cholesterol**	☐ **CVA / Stroke**	☐ **Parkinson's**
☐ **Multiple Sclerosis**	☐ **Headaches / Migraines**	☐ **Loss of Consciousness**
☐ **Incontinence**	☐ **Gout**	

SECTION C — ADDITIONAL INFORMATION

This information may have an indirect impact on your speed and quality of recovery.

☐ **Smoker**	☐ **Medications** YES ☐ NO ☐ Which ones:

HANDEDNESS ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

WOMEN — IF APPLICABLE ☐ Pregnant ☐ Post-Csection

☐ **Other Condition**

SECTION D — SENSITIVE INFORMATION

This information is collected because it has a direct impact on the safety or effectiveness of certain techniques in your treatment plan. It is shared with third parties only with your explicit consent, except when required by law.

☐ **Herpes / HIV / Hepatitis**	☐ **Alcohol / Drug Use**	☐ **Mental Health**

E — Consents to Collection and Disclosure

By checking the boxes below, you consent to the use of your personal information for the specified purposes.

☐ **Collection and Use for File Management**

I consent to PhysioOutaouais collecting and using my personal and health information to manage my care, create and maintain my physiotherapy file, and specifically to monitor my treatments.

☐ **Disclosure of Records — Physician, Employer, CNESST / SAAQ / WSIB**

I authorize PhysioOutaouais to send a copy or report of my file to the following individuals or organizations: *(please specify)*

☐ Physician(s) ☐ Employer ☐ CNESST / CSPAAT / SAAQ ☐ Other:

This authorization is valid for the duration of the initial course of care that prompted this visit. Any use for another purpose will require re-validation of your consent.

☐ **Third Party Records Request Authorization**

I authorize the following institution: to forward the following information or file to PhysioOutaouais:

Specific consent will be requested if any of the following applies to your situation: telerehabilitation, presence of a trainee during your sessions, use of photos or videos for therapeutic or training purposes, satisfaction surveys, testimonials or public reviews, marketing communications.

F — Cancellation Policy

Your physiotherapist is paid per session and is therefore not compensated in your absence. Paying organizations (CNESST, WSIB, SAAQ) do not pay for missed appointments and require that no show be reported, which may result in the termination of your covered services.

☐ I have read and accept the consequences of a no-show without 24-hour notice. I understand that an amount of up to 50% of the treatment cost may be charged at my physiotherapist's discretion.

Notice of Consent to Collection and Use of Personal Information

The personal information collected in this form is used for the purposes indicated in each section, in accordance with the *Act respecting the protection of personal information in the private sector* (Law 25) and the *Act respecting health and social services information* (Law 5). For more information, consult our **Privacy Policy**, available at the front desk and at physiooutaouais.ca. You may modify or withdraw your consent at any time by contacting our privacy officer at info@physiooutaouais.ca or by speaking directly with your physiotherapist. Modifying or withdrawing certain aspects of your consent may impact the services we are able to provide. Your consent may be re-validated periodically in certain situations: changes to the purposes of collection or use, updates to our Privacy Policy, significant changes to your file, or a significant amount of time elapsed between your sessions.

Consent to Care

Consent to physiotherapy care will be obtained and validated verbally by your physiotherapist, after explaining your treatment plan, at your first session or when changes are made to the treatment plan.

I declare that the information provided in this form is complete and accurate to the best of my knowledge. I understand that I may at any time ask my physiotherapist questions about my treatment plan or consult PhysioOutaouais' **Privacy Policy** for information on the collection and use of my personal information.

Patient Signature (14 years or older)	Date (YYYY / MM / DD)
Authorized Parent or Guardian's Signature (if applicable)	Relationship to Patient
Physiotherapist's Signature	Date (YYYY / MM / DD)