ODPC Patient Registration		File No.
Surname **First**	**Male** **Female**	**Family Physician** **Telephone**

Health Card No.											**Version Code**	**DOB** DD MTH YR
Address											**City**	**Postal Code**
Tel. No. **Bus. No.** **Cell. No.** **E-Mail**											**Extended Health Insurance provider** **Group No.** **Policy No.**	

Diagnosis	Diag Code	**Initial Assessment** **Physio**

Is your injury or pain the result of a motor vehicle accident? ☐ **No** **Yes** ☐ **Date of Accident**

Insurance Co. _____ **Claim No.**

Name of Adjuster _____ **Policy No.**

Tel No. _____ **Fax No.** _____ **Email**

Is this an accident under Workers' Compensation? ☐ **Yes No** ☐

WSIB Claim No. **Date of Accident**

Please answer the following as accurately as possible. The information is treated confidentially and will be used to ensure a proper Physiotherapy Assessment.

Occupation _____

General Health

1. Do you have heart disease? Yes ☐ No ☐
   - Have you ever had a heart attack? Yes ☐ No ☐ If yes, when? _____
   - Have you ever had bypass surgery? Yes ☐ No ☐
   - Do you have angina? Yes ☐ No ☐
   - Do you ever experience heart arrhythmia? Yes ☐ No ☐
   - Do you have a pacemaker? Yes ☐ No ☐
   - Do you use nitro spray or tablets? Yes ☐ No ☐
   - Do you have high blood pressure? Yes ☐ No ☐
   - Have you ever had cancer? Yes ☐ No ☐ If yes, when? _____
   - Have you ever had deep vein thrombosis? or blood clot? Yes ☐ No ☐
2. Do you have lung disease? Yes ☐ No ☐
   - Chronic obstructive pulmonary disease? Yes ☐ No ☐
   - Emphysema? Yes ☐ No ☐
   - Asthma? Yes ☐ No ☐
   - Do you use inhalers? Yes ☐ No ☐

Please complete the other side of this form.

File No.	DOB DD MTH YR

3. Have you ever had a stroke?	Yes ☐ No ☐	If yes, when?	
4. Do you have Parkinson's Disease?	Yes ☐ No ☐	Comment	
5. Do you have osteoporosis?	Yes ☐ No ☐	Comment	
6. Are you diabetic?	Yes ☐ No ☐		
Do you take insulin?	Yes ☐ No ☐		
7. Do you suffer from fainting or dizzy spells?	Yes ☐ No ☐		
8. Do you have any arthritic or joint problems that restrict your activity level?	Yes ☐ No ☐	Comment	
9. Have you ever had any hip, knee, ankle, or back conditions that restrict your activity level?	Yes ☐ No ☐	Comment	
Have you had any fractures in the past year?	Yes ☐ No ☐	If yes, specify	
Have you had a hip replacement?	Yes ☐ No ☐	Right side ☐	Left side ☐
Have you had a knee replacement?	Yes ☐ No ☐	Right side ☐	Left side ☐
Do you use any walking/mobility aids?	Yes ☐ No ☐	Cane ☐	Walker ☐
Do you wear foot orthotics?	Yes ☐ No ☐		
Do you have any metal implants?	Yes ☐ No ☐		
Do you require any assistance with transferring from a sitting to a standing position?	Yes ☐ No ☐		

Other

1. Do you have a visual impairment?	Yes ☐ No ☐	
Do you normally wear eye glasses?	Yes ☐ No ☐	
2. Do you have a hearing impairment?	Yes ☐ No ☐	
Do you normally wear a hearing aid?	Yes ☐ No ☐	
3. Are you currently pregnant or think you may be?	Yes ☐ No ☐	
4. Have you ever or currently smoke?	Yes ☐ No ☐	

Are you currently taking any medication(s)? No ☐ Yes ☐ If yes, please list below
Do you have any other significant conditions that have not already been indicated on this form?
If my services are covered by OHIP, I consent to the Ottawa & District Physiotherapy Clinic releasing the following information to the Ministry of Health and Long Term Care: 1. Name and Date of Birth 2. Ontario Health Number 3. Description of the Physiotherapy services, incl. dates, provided to me by the Clinic.

I understand that I will be charged $50 for a missed appointment or for not cancelling with minimum 24 hours notice.

☐ I am signing on my behalf.

☐ I am signing as a parent, or person who is lawfully entitled to give or refuse consent, on behalf of a child under the age of 16.

☐ I am signing as the guardian of the person, or attorney for personal care of an incapable adult.

Signature of Patient/POA/Guardian _____ *Date* _____