First Care

PHYSIOTHERAPY
&
REGISTERED MASSAGE THERAPY
CLINIC

Welcome!

Here's what you can expect on your first visit with us:

- You will provide us with your health information
- The Patient Coordinator will introduce you to the Physiotherapist
- Your Therapist will assess you
- Your Therapist will explain your treatment plan
- You will schedule your treatments and referrals with the Patient Coordinator
- The Patient Coordiantor will present any recommended rehab devices and/or healthcare aids
- The Physiotherapy Assistant (PTA) will conduct your treatment as directed by the Physiotherapist
- The PTA will demonstrate to you any exercises prescribed by the Physiotherapist

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EXTENDED HEALTH CARE INSURANCE COVERAGE

Patient Information

Family Name: _____ First Name: _____ Middle Initial:____
Address: _____ _____
City: _____ Province:_____ Postal code: _____
Date of Birth: (Year: Month: Day:)
Telephone No.: Cell:_____ Home:_____ Work (optional):_____
Email Address:_____ Health Card No.:_____
Emergency Contact Name & No.:_____

Referral (Please list)

Family Physician:_____ Referring Physician:_____ Other_____

What were you referred for? (Circle all that apply)

Physiotherapy Occupational Therapy Chiropractic Massage Therapy

Were you hospitalized for your injury? ☐Yes ☐No If Yes, Which Hospital?_____

Insurance Company

Name: _____ Telephone No.: _____
Address: _____
Policy Group No.: _____ Division No.:_____
Certificate ID No. or Plan No.:_____
Name of Policy Holder:_____
Policy Holder's Date of Birth: _____
Employer: _____

Limitations: (Physiotherapy)

Deductible: _____
Maximum Amount Calendar Year: _____
Fiscal Year: _____
Number of Treatments Per Year: _____
Massage Therapy_____
Orthotics: _____
Orthopaedic Shoes: _____

Do you send payment to your provider? _____

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Coverage

☐ Extended Health Coverage ☐ Private Coverage ☐ Motor Vehicle Accident ☐ Workplace Injury (WSIB) ☐ No Coverage

Insurance Benefits

Date of Injury (mm/dd/yy) _____ Name of Policy Holder:_____ Policy/Claim No.:_____
Name Of Employer:_____
Name of Adjudicator:_____ Phone No.:_____ Fax:_____
Address of Adjucator:_____ City:_____ Prov.:____ Postal Code:_____
Name of Insurance Company:_____ ID/Certificate Perm No.:_____
Have you completed Accident Benifits Package (OCF1)? ☐ Yes ☐ No ☐ Not Applicable
Were you treated for previous injuries sustained? ☐ Yes ☐ No

Health

Do you presently or have you ever had any of the following? (Check all that apply)

- Currently Pregnant
- Allergies
- Asthma
- Anxiety
- Depression
- Thyroid Problems
- High Blood Pressure
- Cancer
- Diabetes
- Pacemaker
- Heart Problems
- Stroke
- Arthritis
- Cronic Fatigue/Fibromyalgia
- High Cholesterol
- Fatigue
- ADHD
- Parkinsons Disease
- Skin Disease or sensitive
- Arthritis
- Cronic Fatigue/Fibromyalgia
- Fatigue
- High Cholesterol
- Infections
- Viral Hepatitis
- Epilepsy / Seizures
- Liver disease (Fatty Liver)
- HIV/AIDS
- Sterss/lack of sleep

Please list your current medications:

Please indicate any major surgery or dental work you've had: