ASCENT
PHYSICAL THERAPY & PERFORMANCE LAB

INTAKE FORM

First Name: _____ Last: _____
Date of Birth (YYYY/MM/DD) _____ Age: _____ Male / Female
Address: _____ City/Town/Prov: _____
Postal Code: _____ Email: _____
Phone: Home:_____ Work:_____ Cell:_____
Place of Employment:_____ Occupation:_____
Emergency Contact:_____ Phone: _____
Alberta Health Number:_____ Extended Health: **PLEASE SHOW INSURANCE CARD TO RECEPTION**

How did you hear about this Clinic? (**Circle One)** Friend/Family Website Physician Other: _____

Family Physician:_____ Clinic: _____
Surgeon:_____ Hospital:_____
What medications are you on? (if any)_____
What is your primary area of concern? _____
Do you have any of the following? Allergies, Blood Clots, Cancer, Diabetes, Disk Problems, Epilepsy, Headaches, Heart Attack, Hepatitis, High Blood Pressure, Joint Replacements, Numbness, Osteoporosis, Pacemaker, Pregnant, Respiratory Condition, Skin Rashes, Thyroid Condition, Varicose Veins**. (Circle all that apply).**

Motor Vehicle Accident Claim Information: Policy Number: _____ Claim Number: _____
Insurance Company:_____Date of Accident:_____
Adjuster Name, Phone & Fax Number:_____

Workers Compensation (WCB) Claim Information: **(Circle One)** WCB Alberta or WorkSafeBC
Claim Number:_____ Date of Accident:_____
Place of Employment:_____ Occupation:_____
Work Address:_____ Phone:_____

PHYSIOTHERAPY AND MASSAGE THERAPY TREATMENT AUTHORIZATION

Medical Information obtained for my treatment will be maintained in my patient file, is confidential and will not be released to any outside sources without my written permission. (**Please initial all items below**).

____ **I authorize Ascent Physical Therapy to use my personal information for verification of direct billing with insurance companies (if applicable).**
____ **I hereby give Ascent Physical Therapy permission to communicate information about my health and/or injury to my coach, teacher, family doctor, or other health care provider.**
____ **I consent to treatment by a Physical Therapist that may involve the use of acupuncture and/or IMS relevant to my diagnosis (if applicable).**
____ **I am aware that I can terminate my massage/physiotherapy treatment at any point in the session at my discretion, without reason.**
____ **I understand that I am receiving treatment from a Physical Therapist or Massage Therapist and that I am responsible for any treatment costs incurred.**
____ **I understand that Ascent Physical Therapy has a 24 hour cancellation policy, and that I am responsible for applicable fees for appointment cancellations that do not adhere to this policy.**

The information provided on this form is complete and to the best of my knowledge.

Patient Signature: _____ **Date:** _____

PHYSIOTHERAPY AND MASSAGE THERAPY CONSENT TO TREATMENT OF A MINOR

By my signing I hereby authorize Ascent Physical Therapy to administer therapy techniques to my child (under 18 years of age) or dependant as deemed necessary.

Signature of Parent or Guardian: _____ **Date:** _____