CORE
Physiotherapy and Rehabilitation Centre Inc.

857 Sackville Drive, Unit D
Lower Sackville, Nova Scotia, B4E 1S1
E: www.corerehab.ca
T: 902-252-2600 **F:** 902-252-8333

PERSONAL INFORMATION:

☐The information in this section has remained unchanged from my last visit with CORE Physiotherapy & Rehabilitation Centre Inc.

Last Name:		**First Name:**	
DOB:		**Health Card Number:**	

Address:			
City:		**Postal Code:**	
Home/Mobile #:		**Work #:**	
Email Address:			

Emergency Contact:		**Emergency Contact #:**	
Referring/Family Physician:		**Physician Contact Information:**	
Occupation:		**Area of Injury:**	

WOKERS' COMPENSATION INFORMATION:

Employer:		**WCB Claim #:**	
Employer Contact:		**WCB Case Worker:**	
Employer Contact Number:		**Date of Accident:**	

Is your injury as a result of work related injury?	Yes	No
Are you off work?	Yes	No
If you are still working, are you on modified duties?	Yes	No

NOTE: If approved by the Workers' Compensation Board (WCB), you will be provided with a claim number that will be used to invoice the WCB directly.

If for any reason WCB declines to cover your Physiotherapy/Rehabilitation claim, **you will be held responsible to pay the outstanding balance on your account.**

Client Signature: _____ **Date:** _____

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NOTE: MSI/Medicare **DOES NOT** cover the Private Physiotherapy treatment in Nova Scotia. Therefore, **you, or your private medical insurance company** is directly responsible for payment of the services provided. Payments are collected on each visit.

Client Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

PATIENT HEALTH SCREEEN

1. Please check ✓yes/no to the following conditions listed below. Your responses will remain confidential.

CONDITIONS	YES	NO	CONDITIONS	YES	NO
Arthritis			Hernia		
Diabetes			Depression		
Thyroid Condition			Osteoporosis		
Dizziness/Fainting			Smoking History		
High/Low Blood Pressure			Raynaud's		
Heart Condition			Sleeping Problems		
Chest Pain			Persistent Cough		
Pacemaker			Vision Difficulties		
History of Cancer			Swallowing Difficulties		
Allergies			Slurred Speech		
Epilepsy/Seizures			Memory Problems		
Shortness of Breath			Balance Problems		
Asthma			Recent Falls/Blackouts		
Bronchitis			Unexplained weight loss		
Other Respiratory Cond.			Groin numbness/Tingling		
Hearing Impairment			Bowel & Bladder Difficulties		
Pregnancy			Headaches		
Metal Implants			Blood Diseases		

2. If you have responded "Yes" to any of the above, please provide details in the space below:

_____
_____
_____

3. Please list any medications you are currently taking.

MEDICATIONS	DOSAGE	PRESCRIBING PHYSICIAN

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4. Have you had any of the following tests completed for the condition/injury you have been referred?

TESTS	YES	NO	When	Results
X-rays				
CT Scan/MRI				
Ultrasound				
Bone Density Test				
EMG/Nerve Conduction				
Other:				

5. Have you any surgeries in the past twelve (12) months? _____

6. Have you had any relevant past injuries (e.g. back, neck, or knee) _____

7. Have you had any past injections? _____

8. Is there anything else we should be aware of your health that has not been covered?
_____
_____
_____

9. Are you following up with your physician regarding your injury? ____Yes ____No.

If so, when is your scheduled appointment? Date: _____

HOW DID YOU HERE ABOUT US!

(Please place a check mark in the appropriate box).

SOURCE	Yes
Yellow Pages	
Physician Referral	
Website	
Facebook	
Location	
Clinic Sign	
Friend/Family	
Other:	

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CONSENT TO COLLECT & RELEASE INFORMATION

CORE Physiotherapy & Rehabilitation Centre Inc. collects personal/personal health information solely for the purpose of providing you with quality care and service, including assessment, treatment and payment of services rendered. This consent will remain in effect for twelve (12) months, though you may withdraw consent at any time by placing a request with the Clinic Manager. The Clinic Manager will discuss with you the risks of withdrawing consent, which may include limited ability to provide assessment or treatment.

I, _____ consent to the collection and use of my personal/personal health information by CORE Physiotherapy & Rehabilitation Centre Inc. I understand that there are risks and benefits associated with providing this consent.

I consent to having CORE Physiotherapy & Rehabilitation Centre Inc. contact the individuals/organizations below to send copies of reports indicating my progress (assessment, progress, functional, and discharge), as well as to contact these individuals to request information that may be assist with my care, such as job demands for return to work planning, X-Ray/MRI results, etc.

_____ Physician/Specialist

_____ WCB Case Manager

_____ Insurance Adjuster

_____ Employer

_____ Lawyer

_____ Other

My consent is indicated by my signature below, and I understand that I may withdraw my consent at any time, effective upon the date of the request;

_____ Client/Guardian Signature

_____ Date

_____ Witness Signature

_____ Date