Synergy Sports Medicine & Rehabilitation - New Patient Form

Please be advised all Information is Private and Confidential.
Privacy Policy in place

Welcome, and thank you for choosing Synergy Sports Medicine & Rehabilitation. We offer quality professional health care. Direct and open communication between you and the staff is vital for proper care. We ask that you fill out the following forms to ensure that you receive the appropriate care that you require. Please note all information is confidential.

Please note that we do not accept MVA or WSIB claims.

Contact Information

□ Mr. □ Mrs. □ Miss □ Ms. □ Dr. □ Sir

Given Legal Name: _____
First Name Last Name

Preferred Name: _____
(if different from above) First Name Last Name

I identify as: □Man □ Woman □Trans □Other _____

Address: _____

City: _____ Province: _____ Postal Code:_____

Phone: Home_____ Work_____

Email: _____

Date of Birth: _____ (DD/MM/YYYY)

Occupation: _____ Hrs/week _____

Emergency Contact: _____ Phone _____

Medical Information

Family Physician: _____ Phone: _____
Address: _____
City: _____ Province: _____ Postal Code:_____
Previous Treatment:
□ Athletic Therapist □ Chiropractor □ Massage Therapist □ Acupuncturist □ Other

Name (or Clinic Name):_____ Date of Last Visit: _____

How did you hear about us?

□ Google
□ Social Media _____
□ Advertisement (Location):_____
□ Media: _____
□ Walk In
□ Referral: _____
□ Other: _____

Would you like to receive our quarterly newsletter packed with valuable free information, updates on promotions and courses offered at Synergy Sports Medicine & Rehabilitation?

_____ Yes, please include me on future mailings.

_____ No thank you.

Please see reverse…

SYNERGY IS A SCENT FREE FACILITY. PLEASE REFRAIN FROM WEARING STRONG SCENTS OR PERFUMES.

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Consent Form

We want you to understand the services that we provide to you and what we do with the personal information that you provide to us. Please let us know of any questions that you have.

Assessment and treatment
Your health care professional will explain to you the procedure for assessment and treatment, and will ask for your consent. Please note that you have the right to ask questions or to withdraw consent at any time during your assessment and treatment.

Collection, use, storage and disposal of personal information
In order to provide health care services, Synergy Sports Medicine and Rehabilitation will collect select personal information from you (for example: contact information, address, health history).

Synergy has a Privacy Policy about the collection, storage, use and disclosure of personal information and about the protection of personal information. You have the right to review your personal information, and the Privacy Policy is available to you upon request. Please let us know of any questions that you may have.

Consent
I have read and understand this information, and give consent to Synergy Sports Medicine and Rehabilitation to:

1. Proceed with assessment and treatment
2. Collect, store and dispose of my personal information according to the Privacy Policy
3. Share my information with the following (provide name, phone number, address if possible):

Family physician _____

Specialist _____

Other health care practitioner's _____

Insurance company _____

_____
(Print name)

_____ Date: _____
(Patient Signature) (DD/MM/YYYY)

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Fee Schedule - All Prices Include HST if Applicable
24 hour cancellation policy in effect for all services
Same Day Cancellation Fee: Half the rate of the Appointment
No Show Fee: Full Rate of the Appointment
Please note that we do not accept MVA or WSIB claims

Registered Massage Therapy		
	30 Minutes	$65.00
	45 Minutes	$100.00
	60 Minutes	$110.00
	75 Minutes	$135.00
	90 Minutes	$155.00
Physiotherapy		
	Initial Physiotherapy Assessment	$125.00
	15 Min Follow-Up Treatment	$60.00
	30 Min Follow-Up Treatment	$85.00
	45 Min Follow-Up Treatment	$120.00
	60 Min Follow-Up Treatment	$140.00
	90 Min Follow-Up Treatment	$180.00
	Physiotherapy/Rehabilitative Pilates	$140.00
Chiropractic		
	Initial Chiropractic Assessment	$125.00
	15 Min Follow-Up Treatment	$60.00
	30 Min Follow-Up Treatment	$85.00
	60 Min Follow-Up Treatment	$140.00
Private Pilates (not typically covered by extended health benefits)		
	60 Minutes	$90.00-$115
	30 Minutes	$55.00
Osteopathy		
	60 Minutes	$140.00
Acupuncture		
	Initial Acupuncture Assessment	$125.00
	15 Min Follow-Up Treatment	$60.00
	30 Min Follow-Up Treatment	$85.00
	45 Min Follow-Up Treatment	$120.00
	60 Min Follow-Up Treatment	$140.00
	90 Min Follow-Up Treatment	$180.00
NSF Cheques		$35.00 Total

I, _____ hereby agree that I have read and clearly understand the above information, I fully understand the fees for service and am aware that I am responsible to make payments for all services provided.

_____ Date: _____

(Patient Signature) (DD/MM/YYYY)

*Prices subject to change without notice

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Email Communication Consent Form for Patient/Substitute Decision Maker

I, _____, acknowledge that I have read and fully understand this consent form. By signing this form I agree that:

- I wish to use email as one of the ways in which to receive communication with clinicians/staff associated with Synergy Sports Medicine & Rehabilitation.
- I understand the risks associated with communication by email between Synergy Sports Medicine & Rehabilitation clinicians/staff and me, and I consent to the conditions and responsibilities outlined in the accompanying **email communication letter** dated July 24, 2013.
- I will comply with any further instructions that the Synergy Sports Medicine & Rehabilitation clinicians/staff may impose to communicate with patients/substitute decision makers by email in the future.
- I acknowledge the rights of the Synergy Sports Medicine & Rehabilitation Medicine clinicians/staff to, upon the provision of written notice, withdraw the option of communicating by email.
- I hereby waive, release, and discharge from any and all liability, Synergy Sports Medicine & Rehabilitation, its employees, and all physicians connected in any way with me as a patient, for any complications which may arise from the use of email.
- I indemnify and hold harmless the entities or persons noted above from any and all liabilities or claims made by other individuals or entities as a result of my decision.
- I agree to abide by the terms of this agreement and consent.
- Any questions I may have had were answered to my satisfaction.

Email address (please print clearly)

_____

_____ Date: _____

(Patient Signature) (DD/MM/YYYY)

- ❑ This consent for email communication also applies to the records of my dependent children under 16 years of age (if applicable).

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In order to allow us to provide you with the best possible care, please fill out this form as accurately as possible.

Medical History

What is your main complaint? (if you have been given a medical diagnosis please include it):

_____

How long have you had this complaint?:

_____

List previous hospitalizations (surgery, illness, etc.): _____

List other injuries (MVA, dislocations, sprain etc.):_____

Are you currently pregnant? _____ Number of pregnancies _____

Number of children_____Painful or heavy menstruation? _____ Menopause? _____

Do you have or have you ever had (check all that apply):

- ❑ Crohn's/ Colitis
- ❑ Gall Stones
- ❑ Stomach/GI Ulcer
- ❑ Tuberculosis
- ❑ Chicken Pox/Shingles
- ❑ Poor Circulation
- ❑ Phlebitis
- ❑ Congestive Heart Failure
- ❑ Stroke
- ❑ Rashes/Eczema
- ❑ Varicose Veins
- ❑ Bruise Easily or Bleeding Disorder
- ❑ Sensitive Skin
- ❑ Problem Acne
- ❑ Arthritis/Rheumatoid Arthritis
- ❑ Plantar Warts of the feet/hands
- ❑ Psoriasis
- ❑ Pacemaker or Similar Device
- ❑ Gynecological Conditions
- ❑ Allergies
- ❑ High/Low Blood pressure
- ❑ Dermatitis
- ❑ Prolonged Bleeding
- ❑ Heart Disease
- ❑ Lung Disease
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Thyroid Disease
- ❑ Diabetes
- ❑ Cancer (type):_____
- ❑ Hepatitis
- ❑ HIV/AIDS
- ❑ Sexually Transmitted Infection
- ❑ Epilepsy/Seizures
- ❑ Migraine/Headaches
- ❑ Emphysema
- ❑ Chronic cough
- ❑ Ear problems

Is there a family history of any of the above? _____ If so, please list:

_____

List all that are taken:

Prescription Medication

Supplements, Vitamins, Herbs, Antacids

Lifestyle

Please check all that apply:

- ❑ alcohol — Number of drinks (e.g. wine, spirits, beer) per week: _____
- ❑ caffeine — Number of drinks (e.g. coffee, tea) per day: _____
- ❑ smoking — Number of cigarettes per day: _____
- ❑ exercise — Number of hours per week: _____ Type of Exercise:

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Systemic

Please check any complaints you currently have and indicate the severity

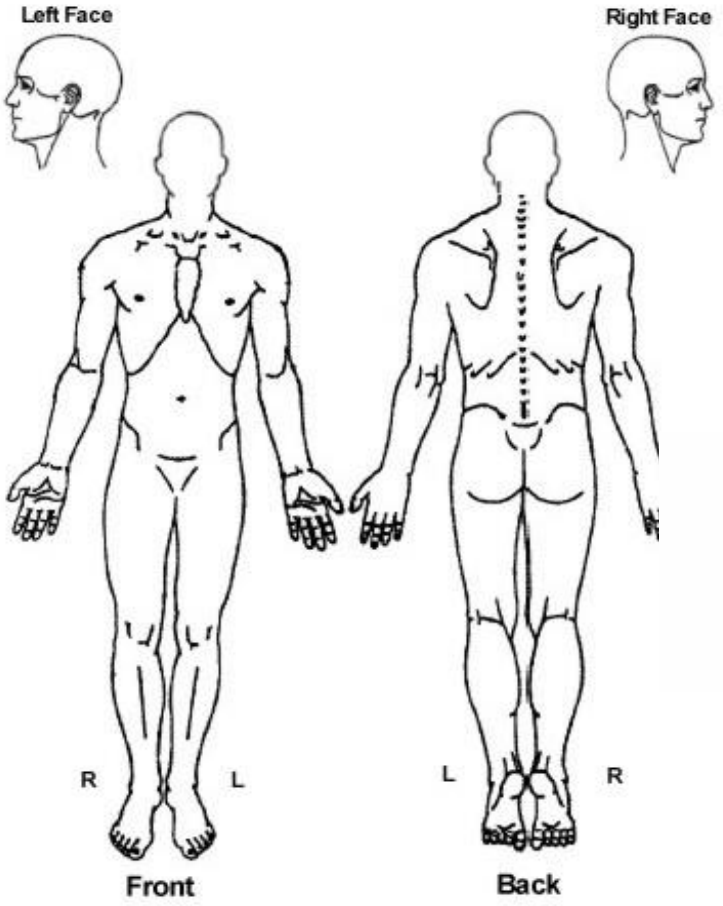
	least				most	Other (please list):
❑ Diarrhea	❑	❑	❑	❑	❑	
❑ Constipation	❑	❑	❑	❑	❑	
❑ Abdominal Discomfort	❑	❑	❑	❑	❑	
❑ Poor Appetite	❑	❑	❑	❑	❑	
❑ Fatigue	❑	❑	❑	❑	❑	
❑ Vision Problems	❑	❑	❑	❑	❑	
❑ Hearing Problems	❑	❑	❑	❑	❑	
❑ Tinnitus	❑	❑	❑	❑	❑	
❑ Shortness of Breath	❑	❑	❑	❑	❑	
❑ Asthma	❑	❑	❑	❑	❑	
❑ Dizziness	❑	❑	❑	❑	❑	
❑ Difficulty Concentrating	❑	❑	❑	❑	❑	
❑ Stress	❑	❑	❑	❑	❑	
❑ Depression	❑	❑	❑	❑	❑	
❑ Insomnia	❑	❑	❑	❑	❑	

In the diagrams provided below, please mark the areas on your body, which you feel best represent the pain or sensation(s) you are experiencing. Please include all areas. Use the symbols provided below.

Symbols**:**

Numbness: ---------- Pins & Needles: :::::::::::: Burning: XXXXXX

Stabbing & Sharp: oooooo Dull &Aching: ++++++ Stiff & Tight: ||||||||||



Please rate your level of pain along the line, with "None" being no pain at all, and "Max" being the worst pain you have ever felt.

None Max

OM WEARING STRONG SCENTS OR PERFUMES.