MSK Rehab Registration Form

Patient Name:

First Name: _____ Last Name: _____

Date of Birth: MO___ Day___ YR___ Gender: Female ( ), Male ( ), Other: _____

Address: _____ City: _____ Postal Code: _____

Tel: (H) _____ (W) _____ (C) _____

Email: _____

Emergency Contact Name: _____ Tel: _____

Referral Information:

Referring Source: _____ Family Physician: _____

WSIB Claim Information:

Claim No.: _____ Date of Injury: _____

Employment Information:

Employer: _____ Occupation: _____

Parent/Guardian (if patient is a minor):

First Name: _____ Last Name: _____ Tel: _____

Address: _____ City: _____ Postal Code: _____

Health Information:

Area of Issue/Injury: _____ Date of Injury: _____ Previous Physiotherapy: Yes ( ) No ( )

Previous Surgery/Illness (with dates): _____

Current Medications: _____

Other Medical Conditions: _____

Females – Is there a possibility that you are pregnant? Yes ( ) No ( )

Are you receiving any other treatment at this time? Yes ( ) No ( )

Do you have any metal in your body? (Pacemaker, plates, screws, replacements, etc.) Yes ( ) No ( )

Please sign consent on back of form

Physiotherapy Informed Consent Form

Please read the following statements and sign below.

- I consent to an examination and treatment performed by a licensed physiotherapist. The results of this exam will be used to develop a treatment plan to meet my specific goals. I understand that my treatment may involve physical and electrical modalities, acupuncture, stretching or mobilizations and exercise programs.
- I understand that MSK Rehabilitation and Bracing is jointly owned by Robert Chalmers, Dr. Nick Bayley, Dr. Chris Geddes, Dr. Paul Grosso, Dr. Tom Hupel, Dr. Rick Lau, Dr. Matthew Snider, and Dr. David Stevens.
- I understand that I may stop the assessment or treatment procedure at any time.
- I understand that if at any time I am not comfortable with; and/or do not understand the treatment being received I will ask the physiotherapist for further clarification.
- I must inform my physiotherapist of any contagious or infectious condition I may have.
- I understand that parts of my program may be provided by an assistant under the direction of my physiotherapist.

Health Information Custodian: Robert Chalmers – MSK Rehabilitation - (519) 603 – 0641

My signature below indicates that I have read and understood all the above information.

_____	_____	_____
Signature of Client	Witness	Date

If client is under 16 years of age, the following section must be completed by a parent or guardian before

I have read and fully understand all of the above information and give my permission to have _____ assessed and/or treated at MSK Rehabilitation and Bracing.

_____	_____	_____
Signature of Parent/Guardian	Witness	Date

MSK Rehabilitation and Bracing

435 King Street North, Waterloo, ON, N2J 2Z5

(T): (519) 603-0641 (F): (519) 603-0650