Gaia Integrative Clinic
A division of 506703 NWT Ltd.
blending science and nature

Physiotherapy-Adult-Patient Information and Consent Form

Please complete the following information in full:
☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms

First Name: _____

Middle Initial: _____

Last Name: _____

Address: _____
Suite/Apt./Unit No: _____
City: _____ Province: _____
Postal Code: _____

Gender: ☐ Male ☐ Female Date of Birth: _____
Month / Day / Year

Work Phone:_____ Extension: _____
Home Phone: _____ Mobile Phone: _____
Fax Number:_____ Other Phone: _____
E-mail: _____
Preferred contact method: _____
May we leave a message? _____

Primary Practitioner: _____
Family Doctor
Name: _____ Phone Number: _____
Address: _____

Emergency Contact
Name: _____ Phone Number: _____
Relationship: _____

How did you hear about Gaia Integrative Clinic?
☐ Referral ☐ Website ☐ Newspaper ☐ Yellow Pages
☐ Advertisement ☐ Friend/Family ☐ Other:_____

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I, the undersigned, voluntarily consent to the procedures and treatments provided to me at Gaia Integrative Clinic. I acknowledge and accept that there may be risks associated with these procedures and treatments, and that the risks will be explained to me in a manner that I can understand prior to any treatment. With this knowledge, I understand and acknowledge that I may ask questions regarding my treatment at any time and that I am free to withdraw my consent and discontinue participation in any procedures or treatments at any time. I further understand and acknowledge that no guarantees have been given to me by Gaia Integrative Clinic or any of its practitioners or personnel regarding cure or improvement of my condition.

I hereby consent to the collection, use and/or disclosure of my personal information for purposes related to the delivery of patient care and other related uses at Gaia Integrative Clinic. I understand that a record will be kept of the health services provided to me. I further understand that my personal information including this record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law.

I hereby acknowledge and agree that I am financially responsible for all payments owing for services received at Gaia Integrative Clinic. I understand and agree that payment must be made at the time services are rendered and/or at the time products are purchased. Additionally, I am aware of the clinic's policy for missed or cancelled appointments. I agree to pay the charge of 50% of the cost of a scheduled visit should I miss or cancel or wish to change a previously scheduled appointment without providing a minimum of 24 hours advance notice.

_____
Patient's Name

_____ _____
Patient's Signature Date

P.O. Box 1401, 4907-47 street, Yellowknife, X1A 2P1•Phone: 867-873-3669• Fax: 867-873-5642
www.GaiaND.com

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Physiotherapy Intake Form

Is this your first time to physiotherapy? Yes No

If no, when was your last visit? _____

Main Complaint:

If you are experiencing pain or numbness/tingling, please describe the area(s) affected:

_____

_____

_____

If you are not experiencing any pain or altered sensation, please describe your reason for seeking physiotherapy:

_____

_____

Is this injury work-related (WSCC)? Yes No

Is this injury from a motor vehicle collision (MVC)? Yes No

If you answered yes to either of these questions, please provide your claim information below:

Date of Injury: _____

Insurer/Employer Name: _____

Insurer/Employer Address and Phone: _____

Policy # or Claim #: _____

_____

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Please indicate if any of these symptoms or conditions apply to you:

Females:
Are you pregnant, or planning on becoming pregnant? Yes No _____
Due Date
Number of pregnancies _____ **Number of children** _____

Pacemaker	Metal implants	Pregnancy	Bowel/bladder changes
Diabetes	Dizziness/fainting	Vision changes	Ringing in the Ears
Cancer	Diabetes	Heart condition	Epilepsy/seizures
Osteoporosis/penia	Night pain	Fever	Changes in body weight

Sexually transmitted infection (STI)

Consent to Shared Files

In order to facilitate communication between both your physiotherapist and chiropractor(s), the clinical staff would like to share files pertaining to your care. Please check the box below that pertains to you:

☐ I consent to shared files between Dr. Carrie Lehman, Dr. Mike Bokor and Kaeleigh Brown PT.

☐ I do not consent to shared files between Dr. Carrie Lehman, Dr. Mike Bokor and Kaeleigh Brown PT.

Your consent may be withdrawn at any time, please let your health care provider know at that time.

Name _____ Signature _____

Date _____ Witness _____

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