BODYWORX
NEW PATIENT INFORMATION

Date _____
Last Name _____ First Name & Middle Initial _____
Birth Date (mm/dd/yy) _____ BC Care Card # _____
(Number from Carecard)
Referring Dr. _____ Family Dr. _____
(If different than Referring Dr.)
Occupation _____ Area(s) of Problem _____
Your Home Mailing Address _____ City _____
Postal Code _____ Email Address: _____
Phone No. (Home) _____ (Work/Other) _____

How did you hear about our Clinic? _____

Coverage: Please circle the number of the section which applies to you.

1. PRIVATE RATE / EXTENDED HEALTH PLANS: Most plans cover physiotherapy.

2. MSP (Premium Assistance/Social Services/Native Status/Disability): If you are premium exempt, you are entitled to partial coverage by the BC Medical Plan – 10 assisted visits per calendar year
- (If you are not Sure, Please ask front desk staff).

The Medical Services Plan requires us to inform you of the total cost of treatment:

	MSP PORTION	PATIENT	TOTAL
Visit(Physio)	$0.00	$90.00(int.) / $75.00	$90.00(int.) / $75..00
Exempt Patient	$23.00	$30.00	$53.00

If coverage is through MSP - Have you had previous **Physiotherapy, Chiropractic, Massage, Acupuncture, Naturopath** or **Podiatry** treatments in this **current** year? ___ How many? ___ At which Clinic(s)? _____

Dear Patient:

This form allows the above named practitioner to receive your MSP reimbursement directly for services that are MSP benefits. Your practitioner, by law, must advise you of his/her full fee and what portion will be reimbursed by MSP. By agreement, your practitioner may not charge you the portion reimbursed by MSP.

Signature of Patient:_____ (Parent/Guardian to sign if patient is under 19)
Date Signed:_____

3. ICBC (Motor Vehicle Claims): CLAIM # _____
Adjuster: _____ Lawyer: _____ Date of Injury: _____
* Please be aware that with ICBC patient visits there is a $30.00 visit charge per treatment – payable each visit (ICBC does not cover this charge directly, you may submit your own receipts to ICBC)

4. DVA (Veterans Affairs): Do you have coverage? YES NO If yes, DVA K # _____

Fees:

- I understand that there is a $50.00 fee, which is my responsibility, for appointments missed or cancelled with less than 24 hours notice.
  Please Initial: _____

please turn page OVER…

Permission to Release Medical Records (Optional, but required for communication with doctor)

I hereby authorize Bodyworx Physiotherapy Clinic to release information regarding my medical history, presenting condition, the treatment I have received and my discharge status to:

My Physician _____ My Lawyer _____ WSBC. _____ I.C.B.C. _____ Other _____

Patient Signature _____ Witness Signature_____

Guardian _____ Date _____

MEDICAL HISTORY

What Medication are you taking, if any?
Medication:

_____
_____
_____
_____

Please advise your physiotherapist if you are taking blood thinners (Coumadin, Hepartin, Warfarin)

For what medical problem?
Problem:

_____
_____
_____
_____
_____
_____
_____

(If unsure, speak with your physiotherapist)

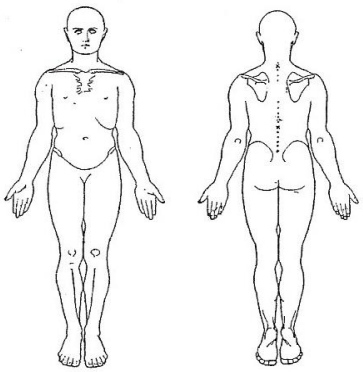
__ Are you Pregnant Y / N / Maybe
__ High / Low Blood Pressure
__ Stroke or Aneurysm
__ Pace Maker
__ Other Heart Condition
__ Varicose Veins
__ Bruise Easily
__ Other Circulatory Condition
__ Diabetes

__ Dizziness / Fainting
__ Nausea
__ Spinal Injury
__ Head Injury
__ Epilepsy / other Seizures
__ Other Neurological condition
__ Asthma
__ Other Respiratory Condition

__ Bone Fracture
__ Arthritis
__ Osteoporosis
__ Rods / Pins / Plates / Shunts
__ Implants _____
__ Transplant _____
__ Cancer
__ Hepatitis
__ HIV
__ Other Contagious Condition

Please describe your current condition & symptoms: _____
_____
_____
_____
How long have you had this condition? _____
How did it start? _____
_____
_____
What aggravates it? _____
_____
_____
What relieves it? _____
_____
_____

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:



Pain: X Spasm: / Tight: +
Pins & Needles: O

Have you ever been hospitalized, had any major accidents, illnesses or surgeries? □ Yes □ No
Please comment: _____
_____
_____

Is there anything else you feel we should know? _____
_____
_____