



JERICHO PHYSIO

When your body talks. We listen.

Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____ Male/Female _____ BC Care Card No.: _____
(M / D / Y)

Address: _____
(Street Address) (City) (Postal Code)

Phone: _____
(Home) (Work) (Cell)

Email: _____

Yes, I consent to receive e-mails from Jericho Physiotherapy

No, please do not send me e-mails

Emergency Contact Name: _____ Number: _____

Family Physician: _____ Referring Physician (if different): _____

How did you hear about our clinic? (Tick)

Patient (Name: _____)

Doctor (Name: _____)

Website

Facebook

Google Ad

Other (please specify: _____)

Is this visit part of:

An **ICBC** claim? Y / N

A **military or DVA** claim? Y / N

A **Worksafe BC** claim? Y / N

Do you have **Premium Assistance** on your MSP? Y / N



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Client Name: _____ Current Date: _____

Occupation: _____

Sports and Interests

Client Health History

What is the reason for your visit?

Related or other problems:

Are you receiving any treatment for the above condition at this time?

Yes No

What type(s)? _____

Have you received any treatment in the past for this?

Yes No

What type(s)? _____ Where? _____

Are you taking any medications or remedies?

Yes No

Names? _____

Have you had any investigations for this matter? (X-rays etc.)

Yes No

Have you had any motor vehicle accidents, fractures or injuries in the past?

Past surgeries? (Nature and dates)

Please indicate conditions presently causing problems, as well as conditions which were a problem in the past.

	Present	Past		Present	Past
Birth & Children			Head/Neck		
Birth Trauma			Headaches		
Feeding Problems			Migraines		
Colic			Jaw problems		
Recurrent ear infections			(pain/clicking/locking)		
Developmental delays			Whiplash		
Behavioural restlessness			Vision problems		
Sleep problems			Ear problems		
Hyperactivity/ADD/ADHD			Fainting		
Learning problems			Dizziness		
Eye motor problems			ringing in the ears		
PDD/Autism			Sinus problems		
			Facial pain		
Respiratory			Closed head injury		
Chronic conditions			Other neurological conditions		
Shortness of breath					
Bronchitis			Other Conditions		
Asthma			Osteoporosis		
Emphysema			Immune deficiency		
			TB		
Cardiovascular			Skin conditions		
High blood pressure			Hepatitis		
Low blood pressure			Diabetes	Onset:	
Congestive heart failure			Epilepsy/seizures		
Heart attack	Date:		Cancer		
Heart disease			Arthritis		
Phlebitis			Susceptible to colds/infections		
Stroke	Date:		High stress levels		
Cardiovascular aneurysm	Date:		Insomnia		
Pacemaker/other device			Fatigue		
Coldness in extremities			Nervousness		
Varicose veins			Numbness and/or tingling		
Arteriosclerosis			Anxiety		
			Depression		
Gastrointestinal			Thyroid	Hyper	Hypo
Heartburn			Gynecological concerns		
Pain before eating					
Discomfort after eating					
Nausea					
Constipation					
Hemorrhoids					
Diarrhea					
Ulcer					

Is there any other information your therapist should know?

Please initial below to indicate you have read this page to completion:

Fee Schedule

Time	Regular Rate	Senior Rate (65+)	MSP Premium Assistance*
30 min	\$85.00	\$80.00	\$65.00
45 min	\$130.00	\$120.00	\$100.00
60 min	\$170.00	\$160.00	\$130.00

***Patients who have Premium Assistance on their BC Medical Services Plan** are also eligible for a partial reimbursement of \$23 per visit, provided they have not used up their 10 paramedical allotments for that calendar year. Our office will transmit dates to MSP electronically on behalf of the client. The client will then receive their \$23 reimbursement directly from MSP.

Patients on ICBC & WorkSafeBC Claims

We do not bill ICBC or WorkSafeBC on your behalf. Patients are responsible for submitting their receipts to ICBC & WorkSafeBC. They will then reimburse the patient at the ICBC or WorkSafeBC rate and at their discretion.

Please inform us if you are on a claim prior to treatment.

Payment to the clinic for all appointments and missed appointments are the responsibility of the client at each visit. The full visit fee will be charged for missed appointments and appointments cancelled with less than 24 hours

I authorize Jericho Sports and Orthopaedic Physiotherapy Clinic/ Physiotherapists to exchange relevant information regarding my medical care with any member of my health care team.

Yes

No



I have read and understand the above information:

Signature of Patient/Guardian: _____

Date: _____

(As of October 15, 2018)