Total Body Health Welcomes You!

Kinesiology Intake

Legal First Name ________________________ Legal Last Name __________________________

Mailing Address _____________________________________ Postal Code _________________

Home Phone _________________ Cell _____________________ Work ___________________

Email Address ____ Newsletter Y ___ N ___

Date of Birth _________________ M ____ F ____ Marital Status _____ No of Children ____

BC Health # _________________

Is this related to ICBC Motor Vehicle Accident Y ____ N ____ Claim # ___________________

Date of Accident __________________ Are you receiving other treatment _________________

Adjusters Name and Phone Number ____

Employer ______________________________ Occupation _______________________________

Referred by _____________________________________ Referred to ______________________

Emergency Contact ____

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Health Information

Circle all that apply

Chest Pain Brought On By Activity	Dizziness	Numbness/tingling
Sport/Leisure Accident	Auto Accident	Diabetes
High Blood Pressure	Heart trouble	Cancer
Asthma	Arthritis	

What is the main reason for your visit?

____

____

Is your current condition getting:

Better Worse Constant Comes and goes

Is your current condition interfering with:

Work Sleep Daily routine Leisure Other

Have you had this condition in the past? If yes, was it resolved?

____

Please list any other treatments you have or are receiving for this condition:

____

Please list any medications you are currently taking:

____

Please indicate your intensity of pain level:

____

0 1 2 3 4 5 6 7 8 9 10

Please circle all symptoms that apply:

Sharp Dull Achy Tingling

Burning Constant Throbbing Numb

Does your pain radiate? Y___ N___

Please list any activities that increase/decrease your pain levels:

____

Please list any x-rays or other imaging tests:

____

Consents

Transactional Emails - You can opt to receive emails to keep you informed of new bookings, changes to your bookings, and reminders for upcoming appointments.

___ Email 2 days before appointment

___ Text Messages (SMS) 2 days before appointment

___ Text Messages (SMS) 2 hours before appointment

___ Phone Call 24 hours before appointment

News and Special Promotions

___ Yes, I would like to receive news and special promotions by email

Consent for Treatment

I hereby consent to participate in the program offered by the Kinesiologist including the use of exercise prescription, electrical modalities and manual therapy techniques. I understand that there may be some discomfort from the rehabilitation depending on the injury. I agree to inform the therapist should any additional symptoms occur. I understand that all exercise programs place a workload on the body to promote improvement and at the same time presents the risk of negative body response to that exercise. I understand that the therapist will give their best care to progress, monitor and care for my injuries. I understand that I am free to withdraw from the involvement of the program, depending on the agreement made between myself and Kinesiologist.

____ I agree ____ I disagree

Kinesiology Fees

Kinesiology is not covered by MSP or WCB. Please check with your extended health insurance provider for coverage. At this time, direct billing is not available for Kinesiology, however Total Body Health will provide you with a receipt for your submission.

____ I am aware

Cancellation Policy

Your appointment time is reserved just for you. In consideration of your fellow patients and practitioner, a minimum of 24 hours notice is required for any cancellations or changes to your appointment. Patients who provide less than 24 hours notice, or miss the appointment, will be charged a cancellation fee of 80% of the appointment fee.

___ I am aware and agree to the cancellation policy

Consent to Release Medical Information to ICBC

Based on Section 28 or Section 28.1 of the Insurance (Vehicle) Act, I consent to share information related to this history, examination, assessment and management of the injury related to the motor vehicle accident with ICBC.
I understand that my consent may be amended or revoked in whole or in part at any time by providing written notice to the clinic or practitioner.

Personal information on this form is being collected under Section 26 of the Freedom of Information and Protection Act (BC) and Section 28 or 28.1 of the Insurance (Vehicle) Act (BC) for the purpose of obtaining a health care report in order to investigate, manage or settle a claim. Questions about the collection of this information may be directed to the adjuster or call 604-661-2800 or contact the Privacy & Freedom of Information (FOI) Department at 151 W Esplanade, North Vancouver, BC V7M 3H9.

If ICBC doesn't accept this claim, I understand that I am responsible for my account and fees for care of Total Body Health.

____ I agree to Consent to Release Medical Information to ICBC

____ I disagree to Consent to Release Medical Information to ICBC

Privacy and Sharing of Information

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

____ I agree

____ I disagree

Patient Signature ____________________________ Date ___________________________