Our Mission: ***Build healthy communities through generations***

Physiotherapy Schedule of Fees

Regular

Consultation + Initial Examination	$90.00
Physiotherapy Visit	$70.00

Seniors/ Students

Consultation + Initial Examination	$70.00
Physiotherapy Visit	$60.00

Missed appointment without 24 hours' notice	$40.00

Wellness Packages

Basic	**Complete**
6 treatments for $378 *($42 savings)* = $63 per visit	12 treatments for $720 *($120 savings)* = $60 per visit

*** All Wellness Packages are fully paid and booked in advance! ***

We work as a team!

Physiotherapy: Injury and rehabilitation.
Chiropractic: Brain, spinal health and prevention.
Massage Therapy: Muscle health and wellbeing.

HealthTweak

Patient # _____

PERSONAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Cell: _____ Work Phone: _____

Gender: _____ Employer: _____ Occupation: _____

E-mail: _____ May we contact you via e-mail? Y / N

Spouse/Partner: Y / N Children: Y / N #: _____

Medical Doctor: _____ Location: _____ Last Visit: _____

Do you want us to communicate with your doctor about your care? Y / N

How did you hear about us? ☐*Existing patient* _____ ☐*Online* ☐ *Doctor* ☐*Other:*_____

HEALTHCARE HISTORY

Have you ever seen? ☐ Chiropractor ☐ Physiotherapist ☐ Massage Therapist ☐ Naturopath

Date of last visit: _____ _____ _____ _____

Have you ever had? ☐ X- Ray ☐ MRI ☐ CT ☐ Ultrasound

HEALTH CHALLENGES

What is the nature of your visit?

☐ Wellness (help me to always be at the highest level of health)

☐ Restorative (help me to restore my health)

☐ Injury (help me to get out of pain)

Please explain your health challenges in order of importance to you:

1) _____

When did it begin? _____ Have you had this problem before? _____

This challenge started: ☐ Suddenly ☐ Gradually ☐ Unknown

Have you noticed any other symptoms associated with this challenge? _____

What does this challenge stop you from doing? _____

Have you seen anyone about this challenge? _____

Prior treatments and results? _____

HealthTweak

Patient # _____

2) _____

When did it begin? _____ Have you had this problem before? _____

This challenge started: ☐ Suddenly ☐ Gradually ☐ Unknown

Have you noticed any other symptoms associated with this challenge? _____

What does this challenge stop you from doing? _____

Have you seen anyone about this challenge? _____

Prior treatments and results? _____

3) _____

When did it begin? _____ Have you had this problem before? _____

This challenge started: ☐ Suddenly ☐ Gradually ☐ Unknown

Have you noticed any other symptoms associated with this challenge? _____

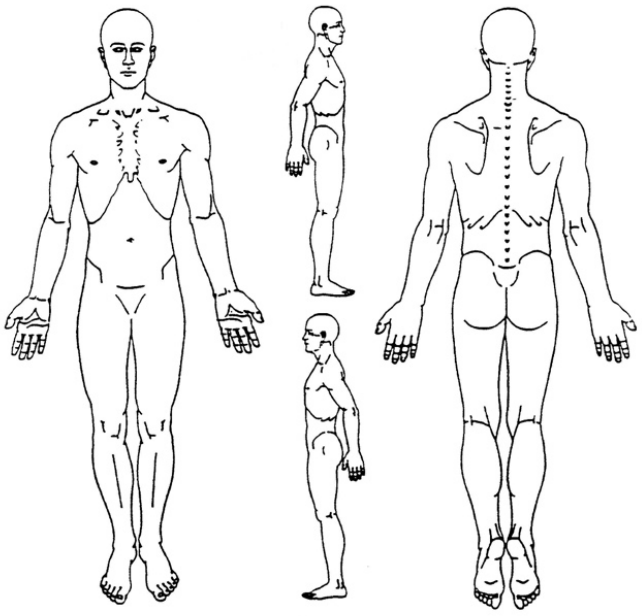
What does this challenge stop you from doing? _____

Have you seen anyone about this challenge? _____

Prior treatments and results? _____

Use letters to indicate type and location of discomfort:

A = Ache
B = Burning
S = Stabbing
N = Numbness
P = Pins & Needles



HealthTweak

Patient # _____

HEALTH INFORMATION

Past injuries (birth complication, teen trauma, emotional trauma, severe stress, injuries, work injuries, car accidents, surgeries, broken bones, reactions to medication, environmental toxins):

_____

_____

_____

_____

Please list any health conditions treated for in the past year:

_____

_____

Please list any hospitalizations including year:

_____

_____

Medication and Supplements

Please list any *medications* you are taking:

_____

_____

_____

_____

Purpose and dose:

_____

_____

_____

_____

Please list any *supplements* you are taking:

_____

_____

_____

_____

Purpose and dose:

_____

_____

_____

_____

Gynecology and Pregnancy

Age of first period: _____ Any chance you may be pregnant? Y ☐ N ☐ If so, # of weeks_____

First day of your last period? _____ How long does your period last? _____

How long is your cycle (first day of menses to last day before they start again)? _____

Are your menses? Irregular ☐ Painful ☐ Heavy ☐

Do you experience hot flashes? Y ☐ N ☐

Date of last PAP : _____ Normal cells ☐ Abnormal cells ☐

Are you using any method of birth control? If yes, what type?_____

How long have you been using this method? _____

Do you experience any changes with your body or emotions prior to your menses/period or at any specific point in your cycle? _____

Have you ever been pregnant? If yes;

# of live pregnancies _____ # of miscarriage _____ # of abortions _____

HealthTweak

Patient # _____

HEALTH CONDITIONS

Please check the following that apply to you:

- ☐ Seizures
- ☐ Allergies _____
- ☐ HIV
- ☐ Rheumatoid Arthritis
- ☐ Diabetes
- ☐ Alcoholism
- ☐ Thyroid Disease
- ☐ Cystic Fibrosis
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Arthritis
- ☐ Other Major Illness
- ☐ Rheumatic Fever
- ☐ Cancer
- ☐ Venereal Disease

General

- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Nausea/vomiting
- ☐ Fevers
- ☐ Lumps
- ☐ Masses
- ☐ Dizziness
- ☐ Double vision
- ☐ Problems swallowing
- ☐ Problems talking
- ☐ Loss of consciousness
- ☐ Loss of balance

Gastrointestinal

- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloating/Gas
- ☐ Laxative use
- ☐ Bad Breath
- ☐ Nausea/vomiting
- ☐ Abdominal cramps/pain
- ☐ Rectal Pain
- ☐ Hemorrhoids
- ☐ Blood in stool

Respiratory

- ☐ Asthma
- ☐ Chronic Cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Coughing Blood
- ☐ Pneumonia
- ☐ Pain w/breathing
- ☐ Mucous Production

Learning Disability

- ☐ ADHD
- ☐ Dyslexia
- ☐ Memory loss
- ☐ Autism spectrum

Neuropsychological

- ☐ Depression
- ☐ Disinterest
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Eating Disorder
- ☐ Concussion
- ☐ Fainting
- ☐ Dizziness
- ☐ Neuropathy
- ☐ Numbness
- ☐ Neurological condition (MS, ALS)

Ear/Nose/Throat/Eyes

- ☐ Vision loss/blurring/pain
- ☐ Hearing loss/ringing
- ☐ Sinus infections/problems
- ☐ Ear infections
- ☐ Nose Bleeds
- ☐ Problems with teeth
- ☐ Night Blindness
- ☐ Sores on lips, tongue or m
- ☐ Facial Pain
- ☐ Recurrent sore throat

Genitourinary

- ☐ Increased frequency
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Discharge
- ☐ Kidney Stones
- ☐ Bladder/Yeast Infections
- ☐ Genital Sores
- ☐ Unable to hold urine
- ☐ Decrease in flow
- ☐ Urgency to void
- ☐ Wake at night to void

Cardiovascular

- ☐ Chest pain
- ☐ Stroke
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Pacemaker
- ☐ Heart Attack
- ☐ Irregular Heartbeat
- ☐ Swelling hands/feet
- ☐ Varicose Veins
- ☐ Blood Clots
- ☐ Impotence

Adrenal

- ☐ Mental fog
- ☐ Poor focus
- ☐ Quick to react
- ☐ Low energy
- ☐ Fatigue
- ☐ Headache
- ☐ Chest tightness
- ☐ Restless legs
- ☐ Susceptible to stress

Doctor Section

- ☐ Vascular
- ☐ Metabolic
- ☐ Aneurism
- ☐ Neoplasm
- ☐ Infection
- ☐ Congenital
- ☐ Trauma

HealthTweak

Patient # _____

LIFESTYLE

What is the biggest stressor in your life? ☐ Family ☐ Work ☐ Social ☐ Financial ☐ Health ☐ Time

What do you love to do in your spare time (hobbies)? _____

How often do you exercise? ☐ Daily ☐ 3-5 days/week ☐ 1-2 days/week ☐ Infrequently

Smoke? Y / N # Packs/week _____ Drink alcohol? Y / N # Drinks/week _____

Recreational Drug use: _____

Hours of sleep? _____ Feel rested? _____

How often do you get cold/respiratory illness per year? _____

	1	2	3	4	5
Where is your current level of health? (circle)	Very low	Poor	OK	Good	Excellent

If you had excellent health, what would you love to be able to do? _____

FAMILY PROFILE

At Health*Tweak* we are here to help you and family live healthy and happy. Please mention below any health conditions or concerns they may have:

Children: _____

Spouse/Partner: _____

Other family members: _____

PERSONAL HEALTH INFORMATION CONSENT FORM

I understand that Health*Tweak* is my health information custodian. I consent to the collection, use and disclosure of my personal health information for treatment and other health care reasons. Health*Tweak* is a multidisciplinary clinic, and therefore treatment notes may be shared between practitioners to best treat the patient.

I understand that to provide me with Massage Therapy, Chiropractic, Physiotherapy, Naturopathic Medicine or any other health care services, Health*Tweak* will collect personal information about me (e.g. birth date, home contact information, health history, etc.)

I understand that Health*Tweak* will only collect, use, or disclose my personal health information with my express or implied consent; unless a collection, use, or disclosure without consent is permitted or required by law.

A termination of doctor-patient relationship may occur under following circumstances: 1. doctor can't provide effective treatment, 2. patient does not pay for care, 3. patient is physically or verbally abusive the doctor.

Name: _____ Name of Witness: _____

Signature: _____ Date: _____

Thank you for completing this form.
If you would like us to *direct bill* your insurance, please provide your insurance information to our receptionist.

HealthTweak Patient # _____

CONSENT TO PHYSIOTHERAPY ASSESSMENT AND TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your physiotherapist and to make an informed decision about proceeding with treatment.

Physiotherapy is a drug-free health care practice. Physiotherapists work in partnership with individuals of all ages to break down the barriers to physical function whether that means working with patients pre and post surgery, helping people come back from illness and chronic disease, injury, industrial and motor vehicle accidents and age related conditions. Physiotherapists also play an important role in health promotion and disease prevention.

Physiotherapy treatment techniques may include, but are not limited to: manual therapy techniques including spinal and joint manipulation and mobilization, electrotherapeutic, thermotherapy or cryotherapy modalities and exercise. Other techniques such as functional dry needling and soft tissue therapy may also be utilized. A number of these may be recommended during your program of care.

Benefits

Physiotherapy treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Physiotherapy benefits include decreasing pain, improving joint mobility, increasing strength and coordination. It can also increase cardio-respiratory efficiency, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with physiotherapy treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Temporary muscle soreness –** techniques used may cause muscle soreness which usually only lasts a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

Physiotherapy treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, physiotherapy treatment, like many common daily activities, may aggravate the disc condition.

The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

- **Risks Specific to Functional Dry Needling -** The most serious risk with FDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe puncture can require hospitalization and re-inflation of the lung. This is a rare complication, and in skilled hands it should not be a major concern. Other risks include injury to a blood vessel causing a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern.

Health Tweak is a Multidisciplinary clinic; therefore other practitioners may have access to your file.
If this poses any concern please let us know.

Alternatives
Alternatives to physiotherapy treatment may include consulting with other health professionals. Your physiotherapist may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns
You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the Physiotherapist's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care.
Inform your Physiotherapist immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE PHYSIOTHERAPIST

I hereby acknowledge that I have discussed with the Physiotherapist the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to physiotherapy treatment as proposed to me.

_____
Name *(Please Print)*

_____ _____
Signature of Patient (or legal guardian) Date

_____ _____
Signature of Physiotherapist Date

HealthTweak

Patient # _____

From:

RE:

DOB:

Dear

Thank you for your kind referral. We have performed an extensive examination and determined the best type of care, specific for this patient.

Diagnosis:

Plan of Care:
Type of Care: ☐ Chiropractic ☐Physiotherapy ☐Massage Therapy ☐Acupuncture
Program of Care: _____/week, for _____ week(s),

Specific Concerns:

Once the patient has undergone a treatment plan, we will fax you a follow-up letter summarizing the type of care and progress that has been made. If you have any questions, concerns or suggestions regarding the patient's plan of care please do not hesitate to contact us.

Thank you for your amazing collaboration.

Name:

Signature: _____

HealthTweak - SouthEnd
1322 Martindale Road, Sudbury, ON P3E 4J5
Phone: 705-222-6983 Fax: 705-222-6985

www.healthtweak.ca