Welcome to Evolution Physiotherapy

Live Life With No Limits

Patient Intake Form

Name: (first)	(last)		Sex: M/F/Other
Phone:	Email:		
Address:		City:	Province:
Postal code:	AHC #		
DOB:(yr/mth/day)		Area of Body:	
Emergency Contact: (name)		(phone)	

If your injury is a result of a work related incident please complete the following:	
Date of injury:	Employer:
Employer Address:	Employer contact:
Employer Phone #:	
Claim #	

If your injury is a result of a motor vehicle accident please complete the following:	
Date of accident:	Insurance Company:
Adjuster name, fax, email:	
Claim #	Break or fracture: Yes or No (please circle)

Please note the Evolution Physiotherapy is able to direct bill to most extended health benefit plans.
It is the responsibility of the patient to know their coverage and limits.

I authorize Evolution Physiotherapy to direct bill the extended health benefits listed on my behalf. I hereby accept financial responsibility for all charges incurred that are not covered by direct billing to the clinic. Assignment will remain in effect unit revoked in writing to the clinic.

I hereby consent to treatment and care provided by therapist(s) at Evolution Physiotherapy. Your therapist will determine the treatment plan that will work best for your condition. Treatments may include manual therapy, cupping, needling, ultrasound, shockwave or other therapies recommended by your therapist.

Please be aware that some treatments may cause bleeding, bruising and/or a temporary increase in soreness. If you have any concerns post-treatment please contact the clinic or speak with your therapist.

Signature of Patient or Guardian:

Date:(yr/mth/day)