INITIAL INTAKE FORM

PLEASE PRINT

Date

Welcome to Green lane Physiotherapy & Wellness! In order to serve you better , please take a moment to complete this form. If you require assistance, please see the receptionist. When Finished, kindly return this form to the front desk.

Have you ever been a patient here before?	☐ Yes	☐ No	If Yes, when?
How did you learn about us? (if referred, please name the referral)			

Patient Information (please complete all of the fields below)

Last Name	First Name		Intl.
Street Address			Home Tel.
City/ Town	Province	Postal Code	Work Tel.
Date of Birth	Gender ☐ M ☐ F		Mobile
Email			
Name of Emergency Contact	Relationship		Emergency Contact Tel.
Name of Family Doctor			Family Doctor Tel.

Case Information (please indicate the reason for your visit and complete all of the related information)

☐ Automobile Accident

Date of Accident

Name of Automobile Insurance Company

Have you already reported your injuries to the insurance company? ☐ No ☐ Yes

Were you employed at the time of the accident? ☐ No ☐ Yes

Do you have a legal representative?

☐ No ☐ Yes (please provide name)

Do you have Extended Health Care benefits coverage?

☐ No ☐ Yes (please provide name of insurer)

☐ Work Injury	Date of Accident First/Last Name	Claim No. (if known)	File No. (if known) Tel/Fax
☐ Slip & Fall	Date of Accident	Claim No. (if known)	File No. (if known)
☐ Sports Injury	Date of Accident	Claim No. (if known)	
☐ Other			

Patient Signature (please print your name, date and sign)

To the best of my knowledge, I certify that the information provided above is true and correct.

Name of Patient	Signature	Date

Please present the following documents:

☐ Driver's License ☐ Health Card ☐ Police Report ☐ Insurance Pink Slip ☐ Extended Health ☐ Other