

PATIENT INFORMATION

Name: _____ Sex: Male Female

Date of Birth: mm/dd/yyyy ____/____/____ Age: _____

Address: _____ City: _____ Postal Code: _____

Phone: (Home) _____ (Cell) _____

May we leave you a message at either number? ..YES NO Email address: _____

How did you find out about us? _____

Occupation: _____ Marital Status: _____

Emergency Contact: (Name) _____ (Relationship) _____ (Phone number) _____

Fee Schedule

Initial Assessment \$ 115 | Subsequent Visit \$60 | Re-Assessment \$90 | Custom Orthotics \$475

(If 3 months or longer since your last visit)

Payment is due at the time services are rendered.

A deposit is required prior to ordering custom-made orthotics.

Cancellation/ No show policy:

We require **24 hours notice** if you are unable to make your scheduled appointment. Without providing such notice, or in the case of a no-show, please be aware that you will be charged the full amount as a Missed Appointment fee.

I have read and understand the financial policy. I agree to pay any and all charges incurred for services rendered and/or items purchased at Miltowne Physiotherapy.

Patient Signature: _____ Date: _____

Patient Name (Print): _____

Patient name: _____ Date: _____

9. Have you had similar symptoms in the past? YES NO

If yes, who did you see?

- Medical doctor Physiotherapist
 Chiropractor Other _____

Please indicate if you have had any of the following conditions, past or present:

| Past | Present | | Past | Present | | Past | Present | |
|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|----------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Abdominal pain | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Ulcer | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid disorder | <input type="checkbox"/> | <input type="checkbox"/> | Excessive thirst |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis | | | | <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver/ gallbladder disorder | <input type="checkbox"/> | <input type="checkbox"/> | Abnormal weight gain/ loss | | | |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Loss of appetite | <input type="checkbox"/> | <input type="checkbox"/> | Joint swelling |
| | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Blurred or double vision | <input type="checkbox"/> | <input type="checkbox"/> | Kidney stones | <input type="checkbox"/> | <input type="checkbox"/> | General fatigue |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness | <input type="checkbox"/> | <input type="checkbox"/> | Kidney disorders | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Muscle incoordination | <input type="checkbox"/> | <input type="checkbox"/> | Bladder infection | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Painful urination | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood clots | <input type="checkbox"/> | <input type="checkbox"/> | Loss of bladder control | | | List any other health problems: |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Prostate problems | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart attack | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Chest pain | <input type="checkbox"/> | <input type="checkbox"/> | Systemic lupus | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Depression | | | |
| | | | | | | | | FEMALES ONLY |
| | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy |
| | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | Birth Control Pills |
| | | | | | | <input type="checkbox"/> | <input type="checkbox"/> | Hormone replacement therapy |

