Activelife
PHYSIOTHERAPY & WELLNESS

Vestibular Physio - Client Intake

Name:_____ Date of Birth:_____

Home Address:_____

Telephone (H):_____ (C):_____ Email:_____

Family Doctor: _____ WHSCC Claim #:_____

Personal Insurance Provider: _____

MCP Number : _____ Exp. Date _____

Medical History - Check which applies:

- ☐ Pregnant
- ☐ High blood pressure
- ☐ Heart attack / angina
- ☐ Stroke
- ☐ Abnormal heart rate or other heart conditions
- ☐ Depression or anxiety disorder
- ☐ Cancer
- ☐ Arthritis / Osteoporosis
- ☐ Diabetes (which type) _____
- ☐ Other _____

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CLIENT CONSENT FORM

Consent for Assessment and Treatment

By signing below, I understand that all healthcare professionals at ActiveLife Physiotherapy and Wellness Inc. hold provincial license and registration. I understand that my participation in all assessments, treatments, and programs provided by health care professionals at ActiveLife Physiotherapy and Wellness Inc. is voluntary and without conflict. I understand that I have a right to verbally refuse assessment or treatment at any time.

Consent for Communication of Medical Information

By signing below, I allow ActiveLife Physiotherapy and Wellness Inc. to share information obtained from my ongoing assessment and treatment with my other health care professionals. I also allow the health care professional treating me at this clinic to receive documentation, if deemed necessary, from the same professionals or institution (i.e. CT scans. bone scans, MRI, ultrasounds, x-rays, etc.)

Email Communication

By signing below, I allow ActiveLife Physiotherapy and Wellness Inc. to use my email to send documentation regarding: appointment reminders, prescribed exercise program delivery, treatment recommendations, newsletters and a customer satisfaction survey as needed.

Billing Agreement

By signing below, I understand the fees associated with the service I am receiving at ActiveLife Physiotherapy and Wellness Inc. I understand that payments for all services must be made on the day of service unless other agreements are made with the clinic manager.

I understand that **Private Health Insurance** may cover a portion of my health care costs and I will pay the remainder of this cost.

WHSCC billing is direct. If you plan to have WHSCC coverage, you must have submitted Form 6 and your employer must have submitted Form 7. If WHSCC has not responded to our request for treatment coverage, your service will be placed on hold until WHSCC has approved our request.

Outstanding Accounts: I understand that in the event that I have an unpaid account, I will receive up to 2 written notices. If my account remains unpaid beyond these 2 notices and 90 days, then my information will be released to a credit recovery institution.

Cancellation and No-Show Policy

ActiveLife Physiotherapy and Wellness Inc. **requires 24 hour notice prior to appointment changes or cancellations. For each individual who cancels or no shows, a fee will be applied to their account.** For WHSCC clients, a notification is sent to case managers for missed appointments as per contract agreement.

Print Name: _____ Witnessed: _____

Signature: _____ Signature: _____

Date: _____ Date: _____

Consent Form-TELEHEALTH SERVICES

Service Provider Info:

Sarah Short, Reg.PT
ActiveLife Physiotherapy and Wellness
6B Church St, Deer Lake, NL
A8A 1E1
sarah@activelifephysiotherapy.com or info@activelifephysiotherapy.com
709-635-9355

Patient Information:

Name:_____
Address:_____

Email: _____
Phone:_____
Any other applicable account info to access service:
_____

I, _____, acknowledge that in consenting to having Sarah Short, Reg.PT communicate with and/or provide telehealth services through phone, email, ClinicMaster and/or Phyzio platform, that I am aware of the following:

1. Risks of using electronic communication

- While the Service Provider will use reasonable means to protect the security and confidentiality of information sent and received using electronic communications, because of the risks outlined below, the Service Provider cannot guarantee the security and confidentiality of electronic communications:
- Use of electronic communications to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Despite reasonable efforts to protect the privacy and security of electronic communication, it is not possible to completely secure the information.

- Employers and online services may have a legal right to inspect and keep electronic communications that pass through their system.
- Electronic communications can introduce malware into a computer system, and potentially damage or disrupt the computer, networks, and security settings.
- Electronic communications are subject to disruptions beyond the control of the Service Provider that may prevent the Service Provider from being able to provide services.
- Electronic communications can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the Service Provider or the patient.
- Even after the sender and recipient have deleted copies of electronic communications, back-up copies may exist on a computer system.
- Electronic communications may be disclosed in accordance with a duty to report or a court order.
- Videoconferencing using no cost, publicly available services may be more open to interception than other forms of videoconferencing
- There may be limitations in the services that can be provided through electronic communications, dependent on the means of electronic communications being utilized
- Email, text messages, and instant messages can more easily be misdirected, resulting in increased risk of being received by unintended and unknown recipients.
- Email, text messages, and instant messages can be easier to falsify than handwritten or signed hard copies. It is not feasible to verify the true identity of the sender, or to ensure that only the recipient can read the message once it has been sent.

2. Conditions of Using Electronic Communications

- While the Service Provider will endeavour to review electronic communications in a timely manner, the Service Provider cannot provide a timeline as to when communications will be reviewed and responded to. Electronic communications will not and should not be used for medical emergencies or other time-sensitive matters.
- Electronic communication may not be an appropriate substitute for some services that the Service Provider offers.
- Electronic communications may be copied or recorded in full or in part and made part of your clinical chart. Other individuals authorized to access your clinical chart, such as staff and billing personnel, may have access to those communications.

- The Service Provider may forward electronic communications to staff and those involved in the delivery and administration of your care. The Service Provider will not forward electronic communications to third parties, including family members, without your prior written consent, except as authorized or required by law.

- Prior to the commencement of the provision of services by the Service Provider through electronic communications, the Service Provider and the patient will establish an emergency protocol to address the following: o Steps to be followed in the event of a technical issue that causes a disruption in the services that are being provided by the Service Provider; and o Steps to be followed in the event of a medical emergency that occurs during the provision of services.

- The Service Provider is not responsible for information loss due to technical failures associated with your software or internet service provider.

- The Patient will inform the Service Provider of any changes in the patient's email address, mobile phone number, or other account information necessary to communicate electronically.

- The Patient will ensure the Service Provider is aware when they receive an electronic communication from the Service Provider, such as by a reply message or allowing "read receipts" to be sent.

- The Patient will take precautions to preserve the confidentiality of electronic communications, such as using screen savers and safeguarding computer passwords.

- If the Patient no longer consents to the use of electronic communications by the Service Provider, then the Patient will provide notice of the withdrawal of consent by email or other written communication.

Acknowledgement and Agreement

I acknowledge that I have read and fully understand the risks, limitations, conditions of use, and instructions for use of the selected electronic communications as described above. I understand and accept the risks outlined above to this consent form, associated with the use of the electronic communications with the Service Provider and the Service Provider's staff. I consent to the conditions and will follow the instructions outlined above, as well as any other conditions that the Service Provider may impose regarding electronic communications with patients. I acknowledge and agree to communicate with the Service Provider or the Service Provider's staff using these electronic communications with a full understanding of the risks in doing so.

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Consent Form-TELEHEALTH SERVICES

I confirm that any questions that I had regarding the provision of physiotherapy services through electronic communications have been answered by the Service Provider.

Name of Patient: _____

Signature of Patient: _____

Witness: _____

Date: _____

VESTIBULAR ASSESSMENT–QUESTIONNAIRE FOR PATIENT

Name: _____ **Date:**_____

Briefly list the problems you would like to see addressed today?_____

When did the problem(s)begin_____
Have you been in an accident? YES NOIf yes,when did it occur? _____
If yes, please briefly describe the accident_____

Have you ever been diagnosed with a concussion? _____
History of migraines? _____
History of motion sickness?_____
Any sensitivity to pressure changes in the environment? _____
Are you taking any medications? _____

Vertigo is a specific form of dizziness where you experience the illusion of movement in the environment, like the 'bed spins'

Have you ever experienced a sustained (longer than 2 minutes) period of spinning vertigo? YES NO
If yes, when did that occur? _____
How many episodes of vertigo have you experienced? _____
With the vertigo, did you have nausea and imbalance? _____

Have you experienced shorter spells of spinning vertigo YES NO
If YES, how long do these spells last? _____
When was the last time the vertigo occurred? _____
Does the vertigo occur:
Spontaneously with no head movement? YES NO
Induced by head positional changes? YES NO
Induced by rolling onto your side? YES NO Right Left

Do you experience a sense of being off-balance (disequilibrium or dizziness)? YES NO
If YES, is the feeling of being off-balance:
constant all the time YES NO
occurring spontaneously (no movement) YES NO
induced by movement YES NO
worse with fatigue YES NO worse in the dark YES NO
worse outside YES NO worse when on uneven surfaces YES NO

Does the feeling of being off-balance occur when:

lying down	YES	NO	sitting	YES	NO
standing	YES	NO	walking	YES	NO

Have you ever fallen (to the ground)? YES NO

If yes, please describe? _____

How often do you fall? _____

Have you injured yourself? _____

Do you stumble, stagger, or side-step while walking? YES NO

Do you drift to one side while you walk? YES NO

If YES, to which side do you drift? Right Left

Past Medical History

Do you have:	Diabetes	Yes	No	Heart Disease	Yes	No	
	High blood pressure	Yes	No	Headaches	Yes	No	
	Arthritis	Yes	No	Neck problems	Yes	No	
	Back problems	Yes	No	Tinnitus (ear noise)	Yes	No	
	Hearing problems	Yes	No	Stroke	Yes	No	
	Visual problems	Yes	No	Neurological problems	Yes	No	

The scale below consists of a number of words that describe different feelings and emotions. Read each item and then indicate how you feel on the average using the numbers **1 2 3 4 5**. Mark the number in the space next to the word.

12345

slightly/not at all	**a little**	**moderately**	**quite a bit**	**extremely**
_____ interested	_____ irritable	_____ jittery	_____ strong	_____ nervous
_____ enthusiastic	_____ distressed	_____ alert	_____ active	_____ excited
_____ ashamed	_____ afraid	_____ upset	_____ inspired	_____ hostile
_____ guilty	_____ determined	_____ proud	_____ scared	_____ attentive

Functional Status

Any increased fatigue? Yes No
Can you drive: In the daytime? Yes No In the nighttime? Yes No
Are you working Yes No
What type of work are you engaged in? _____Not applicable
Are you able to:
Watch TV comfortably? Yes No Read hard copy? Yes No
Go shopping? Yes No Be in Traffic? Yes No
Work on a computer Yes No Be in a noisy place Yes No
Scroll on a smart phone? Yes No Multi-task effectively? Yes No
Any problems with memory? YesNo Any problems with concentration? Yes No
Any light sensitivity?Yes No Any sound sensitivity? Yes No
Do you have stairs in your home? Yes No Do you have trouble sleeping? Yes No

Initial Visit

For the following, please pick the one statement that best describes how you feel?

_____ Negligible symptoms
_____ Bothersome symptoms
_____ Performs usual work duties but symptoms interfere with outside activities
_____ Symptoms disrupt performance of both usual work duties and outside activities
_____ Currently on medical leave or had to change jobs because of symptoms
_____ Unable to work for over one year or established permanent disability with compensation payments