



**NESS PHYSIOTHERAPY
& SPORTS INJURY CLINIC**
3236 PORTAGE AVENUE
WINNIPEG, MANITOBA R3K 0Y9
PH: 953-1650 FAX: 953-1653

Name: _____
Last First Middle Initial

Date of Birth: _____ Age: _____ Sex: _____ Height: _____ Weight: _____
Year / Month / Day

Manitoba Health Number (6 Digit): _____

Address: _____ Postal Code: _____

Telephone :(_____) Work/Cell :(_____)

E-mail Address: _____

Family Physician: _____
(Please include physician's first name/initial and/or clinic)

Who has referred you to our clinic? : _____
(Website, yellow pages, sign, friend, physician, walk-in, magazine stand, other)

Occupation: _____

Employer: _____

Are you currently off work due to Injury? _____ If so, as of what date? _____

WCB _____ Claim#: _____ Case Manager: _____

MPI _____ Claim#: _____ Adjuster: _____

DIRECT BILLING OPTION (one-time \$10.00 administration fee to be paid at first visit.)

If you wish for us to direct bill, the following must be fully completed

Blue Cross Group # _____ Contract # _____
Great West Life Plan # _____ Division # _____ Employee ID # _____

Coverage Percent _____ %
Maximum Benefit \$ _____ / year

PHYSIOTHERAPY & MASSAGE THERAPY CONSENT FORM

Treatment Consent (Check Appropriate Service)

_____ Physiotherapy
_____ Massage Therapy

Signature

Date

The above is to be signed by a parent/guardian if the patient is under 18 years of age.(Please print)

Parent/ Guardian Name: _____

Phone Number: (____) _____

READ AND INITIAL THE FOLLOWING

- Payment in full is required at time of service if not billing 3rd party insurer. _____
- Co-Payment is required at time of service if billing 3rd party insurer. _____
- If claim is denied the patient is responsible for payment. _____
- Failure to remit payment from insurance company to the service provider is considered insurance fraud. _____
- On a time to time basis physiotherapy information may be requested by MPI, WCB, or other insurers. Consent is given to release pertinent medical information in accordance with PHIA. _____

MEDICAL HISTORY

Please check the appropriate response (Yes or No). Do YOU have history of:
(If yes, please explain below.)

	Y	N		Y	N
Osteoarthritis	_____	_____	Diabetes	_____	_____
Rheumatoid Arthritis	_____	_____	Thyroid Problems	_____	_____
Osteoporosis	_____	_____	Glandular Problems	_____	_____
Scoliosis	_____	_____	Skin Conditions	_____	_____
Other Bone or Joint problems	_____	_____	Disease of any Internal Organs	_____	_____
Muscular Disorder	_____	_____	Cancer	_____	_____
Stroke	_____	_____	Communicable Disease	_____	_____
Epilepsy	_____	_____			
Multiple Sclerosis	_____	_____			
Anxiety or Depression	_____	_____			
Other Neurological Disorders	_____	_____			
Heart Attack	_____	_____	Dizziness	_____	_____
Pacemaker	_____	_____	Fainting	_____	_____
Angina	_____	_____	Anticoagulant Therapy	_____	_____
High Blood Pressure	_____	_____	X-Ray Therapy	_____	_____
Low Blood Pressure	_____	_____	High dose Steroid Therapy	_____	_____
Other Heart Problems	_____	_____	Varicose Veins	_____	_____
Breathing Disorders	_____	_____			

Explanation: _____

List Previous fractures, surgeries and hospitalization: _____

Are you currently pregnant? _____ YES _____ NO. If you become pregnant during the course of physiotherapy or massage treatment, please inform your therapist immediately.

