myoworx PHYSIOTHERAPY

PERSONAL INFORMATION

Name: _____ Home Phone # (_____) _____

Address: _____ Bus. Phone # (_____) _____

City: _____ Postal Code: _____

Date of Birth: _____ ***E-mail Address**: _____

Emergency Contact Name: _____ Phone # (_____) _____

CLINIC POLICIES

***Contact Permission:**

☐ I consent to receive email updates including newsletters and announcements.

☐ Please do not send me email updates (except for appointment confirmation/booking details)

Cancellations must be made by 5:00 p.m. the previous day. ***An administrative fee in the amount of 15% of the total cost of treatment will be automatically applied for appointments cancelled after the 5:00 p.m. cutoff. An administrative fee in the amount of 30% of the total cost of treatment will be automatically applied for missed (no-show) appointments. A flat fee of $100(+HST) will be applied for late cancellations or missed appointments with Terry Moore.*** You are personally responsible for this payment. (Note: we do have an answering machine for after-hours calls).

Late Appointment Policy: When you book an appointment, you are scheduled with a kinesiologist for a fixed amount of time after your TM20 treatment. *If you are late for your appointment, you can still complete your treatment, but may not get as much 1:1 time with that kinesiologist as you would if your appointment started on time. If you are very late for your appointment, we may need to cancel your treatment.*

Payments: If **Third Party Payer** refuses to pay your invoice then you are responsible for payment to MMTR Physiotherapy. ***You agree to pay invoices from MyoWorx charged for requests from U.S. insurance companies, lawyers, and any other association for filling out questionnaires and reports by physiotherapists and/or Terry Moore and sending copies of your file. These invoices must be paid before we release this information.*** 2% interest will be charged monthly on overdue payments.

Cell Phones must be turned off while in the clinic, as it may interfere with other equipment within the building and disturb others' treatment session. Please refrain from using cell phones for videos and/or picture taking without getting permission first.

Jackets and bulky items will need to be carried with you throughout your treatment. Please carry any purses, hand bags or other valuables with you throughout your treatments as we cannot be held responsible for any theft or damage to your personal belongings.

Claims: Any legal suits against MyoWorx Physiotherapy or its employees will be void unless first brought against the Insured in Canada, its territories, or possessions

Patient Signature: _____ Date: _____

MEDICAL INFORMATION

Please indicate Yes or No for each question by checking the appropriate box.

POTENTIAL CONTRAINDICATIONS **Do you have any of the following…?**			**GENERAL HEALTH INFORMATION**		
			Do you have Diabetes?	YES ❑	NO ❑
Cardiac Pacemaker	YES ❑	NO ❑	Do you have high blood pressure?	YES ❑	NO ❑
Cancerous lesions at present	YES ❑	NO ❑	Do you have a skin disease?	YES ❑	NO ❑
Latex or rubber allergy	YES ❑	NO ❑	Do you have Epilepsy?	YES ❑	NO ❑
Metal implants (i.e. bone plates or screws) -If yes where:_____	YES ❑	NO ❑	Do you have a history of irregular heart beat or cardiac disturbances?	YES ❑	NO ❑
Recent scar tissue	YES ❑	NO ❑	Do you have a blood disease (i.e. Hepatitis, HIV, anemia, etc.)?	YES ❑	NO ❑
Lack of normal skin sensation	YES ❑	NO ❑	Do you have Tuberculosis?	YES ❑	NO ❑
You are pregnant or, are trying to become pregnant	YES ❑	NO ❑	Do you have any breathing problems?	YES ❑	NO ❑

Is there an open claim for your current injury: ❑No ❑ Auto Insurer ❑ WSIB ❑ Disability ❑ Other

MEDICAL CONDITIONS YOU HAVE OR SYMPTOMS YOU EXPERIENCE

Multiple Sclerosis	YES ❑	NO ❑	Parkinson's Disease	YES ❑	NO ❑
Rheumatoid Arthritis	YES ❑	NO ❑	Tremors anywhere in your body	YES ❑	NO ❑
Fibromyalgia	YES ❑	NO ❑	Osteoporosis	YES ❑	NO ❑
Tinnitus (hearing ringing/noises)	YES ❑	NO ❑	Plugged Ears or Painful Ears	YES ❑	NO ❑
Vertigo / Dizziness / Nausea	YES ❑	NO ❑	Blurred or Double Vision	YES ❑	NO ❑
Migraines	YES ❑	NO ❑	Balance Problems	YES ❑	NO ❑
Post Concussion symptoms	YES ❑	NO ❑	Congestion / Sinusitis	YES ❑	NO ❑
TMJ (Jaw) Pain / tenderness	YES ❑	NO ❑	Post Stroke symptoms	YES ❑	NO ❑
Incontinence (accidental loss of small amounts of urine)	YES ❑	NO ❑	Bothered by frequent urination during the day or an uncomfortable urge to urinate	YES ❑	NO ❑
Bothered by night-time urination	YES ❑	NO ❑	Stomach or bowel pain when going to washroom	YES ❑	NO ❑

Name of Family Physician:		City:		Phone:	
Please list any prescription medications, including creams or lotions:					
Please list any other medical conditions not already indicated:					

How did you hear about us?

Name: _____ Age: _____ Sex: M/F Date: _____
Condition we are treating you for: _____

Did you receive a doctor's referral for our clinic? Y/N
If yes, what is the name of the doctor(s): _____

How did you first hear about MMTR? (please select only one)

- Google Search. What did you search for? _____
- Facebook
- Instagram
- YouTube
- Email Newsletter
- MyoWorx.com/MyoWorx® Social Media
- Invisible Injury Blog
- Doctor's Referral
- Word of Mouth. Name of Person: _____
- Other: _____

Why did you choose MyoWorx Physiotherapy?
_____
_____

Additional Comments:
_____
_____

What is your address? (City, State/Province)
_____
_____

INFORMED CONSENT

I_____ do hereby indicate my informed decision and consent to proceed with treatment at MyoWorx Physiotherapy. I acknowledge that information from questionnaires I complete at the clinic, the numbers I provide regarding my pain levels at each treatment in addition to the equipment readings and the objective assessment measures can be used as data in research studies compiled by MyoWorx and affiliates. I understand that any data collected for research studies will be kept confidential and my identification will remain anonymous and coded. I understand that the purpose of such research is to provide ongoing improvement and development to the therapeutic model and processes used at MyoWorx Physiotherapy.

Patient Signature: _____ Date: _____

CONSENT TO RELEASE / RECEIVE INFORMATION

Please provide the following information for any person(s) or organizations **to who** you would like us to **release / receive information** regarding your treatment and progress at MyoWorx Physiotherapy. This includes administrative information such as appointments schedule.

Family Physician: _____

Employer: _____

H.R. Manager: _____

Family Member: _____

Insurance Company: _____

Case Worker: _____

Specialist: _____

Other: _____

By signing this consent, I_____give permission to MyoWorx Physiotherapy to forward and/or receive medical reports and information relating to my medical condition/accident/injuries to the above listed parties.

Patient Signature: _____ Date: _____