Main Street
HEALTH
Physiotherapy & Health Clinic

Welcome to Main Street Health

Please take the time to fill all applicable questions and Forms to save time on your first appointment.

1. Fill, Save and Print forms and make sure to bring it to your first appointment
   or
2. Fill, Save and Email forms to ***info@mainstreethealth.ca***
   (If you are emailing the forms we will get all required signatures on your first visit)
3. If you have been involved in a **Motor Vehicle Accident** or **Work Place Injury** please copy links provided and open in a new web browser, print or email form with this intake to ***info@mainstreethealth.ca***

Motor Vehicle Accident please also complete the OCF 1 (Application for Accident Benefits):

https://www.fsco.gov.on.ca/en/auto/forms/Documents/SABS-Claims-Forms/1224E.5.pdf

Work Place Injury please also complete the WSIB From 6(Worker's Report of Injury/Disease):

http://www.wsib.on.ca/cs/groups/public/documents/staticfile/c2li/mdex/~edisp/wsib011595.pdf

DO NOT save the PDF version of the form on a public computer. It will allow others with access to the computer to view your personal information

If you have any questions or concerns regarding the intake forms please contact us at 905.524.3709

Main Street HEALTH

Physiotherapy & Health Clinic

460 Main Street East, Unit M3. Hamilton, ON L8N 1K4 T: 905.524.3709 F:905.524.4866 TF:1.866.908.3709
info@mainstreethealth.ca
www.mainstreethealth.ca

Save Form | Print Form | Clear Form

Patient Information *(Please complete all fields below)*			
Last Name	First Name		Patient's Email
Street Address			Home Tel.
City/Town	Province	Postal Code	Work Tel.
Date of Birth (mm/dd/yyyy)	Gender ☐ M ☐ F		Mobile Tel.
Name of Emergency Contact	Relationship		Emergency Contact Tel.
Name of Family Doctor		Family Doctor Tel.	
Employer		Occupation	

How did you hear about our clinic?

☐ Return Patient	☐ Family Doctor	☐ Local businesses _____
☐ Location/Street Sign	☐ Internet	☐ Family/friend referral _____
☐ Website	☐ Facebook/Twitter	☐ Other_____

Main Street Health policies:

1. Please provide 24 hours notice of cancellation for your appointment. A $50 fee will be charged to your account if you do not show up for your appointment or if you choose to cancel within 24 hours of your appointment time.

2. Late arrivals will be seen for the remainder of their appointment time only or rescheduled for another day. It is our goal to stay on schedule to the best of our abilities.

I understand, and agree with, the criteria listed under Main Street Health policies

_____ _____

Signature of patient Date

Consent to communicate via email

Can we email your appointment reminders to you 1 day prior to your appointment ☐ Yes ☐ No
I authorize Main Street Health to contact me via email for appointment reminders and clinic information

_____ _____

Signature of patient Date

Main Street HEALTH
Physiotherapy & Health Clinic

460 Main Street East, Unit M3. Hamilton, ON L8N 1K4 T: 905.524.3709 F:905.524.4866 TF:1.866.908.3709
info@mainstreethealth.ca
www.mainstreethealth.ca

Extended Health Benefits *(If applicable please complete all of the related information)*

Insurance Company: _____

Certificate_____ID_____Policy_____

Employee Name_____Date of Birth _____

Employer Name _____

Employer Address _____

Have you registered for Online Billing? ☐ **Yes** ☐ **No**

Work Place Injury *(If applicable please complete all of the related information)*

Date of Accident_____ Claim Number _____

Employer_____ Occupation _____

Phone_____ Fax _____

Do you have Extended Health Care Benefits? ☐ Yes *(Please complete Extended Health Care section)* ☐ No

Motor Vehicle Accident *(If applicable please complete all of the related information)*

Name of Automobile Insurance Company _____

Date of Accident _____ Policy Number _____ Claim Number _____

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

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

Do you have a legal representative? ☐ Yes *(Please provide name)* _____

☐ No Would you like us to refer you to a legal representative? ☐ Yes ☐ No

Do you have Extended Health Care Benefits? ☐ Yes *(Please complete Extended Health Care section)* ☐ No

Current work status? *(Please complete all of the related information)*

☐ Regular ☐ Light Duty(how long?_____) ☐ Unemployed ☐ Not working due to this problem

☐ Retired ☐ Student ☐ Disabled

Main Street HEALTH
Physiotherapy & Health Clinic

460 Main Street East, Unit M3. Hamilton, ON L8N 1K4 T: 905.524.3709 F:905.524.4866 TF:1.866.908.3709
info@mainstreethealth.ca
www.mainstreethealth.ca

Motor Vehicle Accident / Work place Injury - Accident Description *(Please provide the following in the description)*

1. How did the accident happen?
2. Did you go to the hospital?
3. What part of the body did you injure and feel pain in right away?

Main Street HEALTH
Physiotherapy & Health Clinic

460 Main Street East, Unit M3. Hamilton, ON L8N 1K4 T: 905.524.3709 F:905.524.4866 TF:1.866.908.3709
info@mainstreethealth.ca
www.mainstreethealth.ca

Health History Form

Save Form | Print Form | Clear Form

Health History *(Please complete all of the related information)*

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Stroke/CVA
- ☐ Chest pain
- ☐ Phlebitis/varicose veins
- ☐ Heart disease
- ☐ Pacemaker or similar device(s)

RESPIRATORY

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

COMMUNICABLE DISEASES

- ☐ Hepatitis
- ☐ Skin conditions
- ☐ TB
- ☐ HIV/AIDS
- ☐ Any other communicable diseases or Haemophilia? If so, please describe:

_____

OTHER CONDITIONS

- ☐ Orthotics/arch supports
- ☐ Osteoporosis/Osteopenia
- ☐ Previous/Current Fractures: _____
- ☐ Arthritis - Onset/type:

_____

- ☐ Diabetes Onset/type:

_____

- ☐ Epilepsy
- ☐ Depression
- ☐ Cancer - Onset/type/current state:

_____

_____

- ☐ Allergies/hypersensitivity?

_____

- ☐ Digestive Conditions
- ☐ Organ dysfunction
- ☐ Other: _____

Is there a family history of any of the above conditions? if so, please describe:

_____

_____

- ☐ Loss of sensation (area)

_____

- ☐ Dizziness
- ☐ Urinary/bowel incontinence

HEAD/NECK

- ☐ Ever been knocked unconscious?
- ☐ History of headaches
- ☐ History of migraines/ new onset?
- ☐ Vision loss/changes
- ☐ Dizziness/Double vision
- ☐ Hearing loss/ear condition(s)

PELVIC HEALTH

- ☐ Pregnant, Due date: _____

# of prior pregnancies: _____

# of children : _____

OF SPECIAL NOTE:

Please list any previous surgical procedures and any details/hardware (Ie/ prosthesis, wires, internal pins/fixators):

_____

_____

_____

CURRENT MEDICATION(S)
(Please feel free to provide a copy of any medication lists instead)

1. _____
2. _____
3. _____
4. _____

Primary complaint/injury at this time: