Active Therapeutic Solutions
259 Grange Rd, Guelph ON N1E 6R5
Dr. Edward Finoro & Associates

REGISTRATION FORM

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single / Mar / Div / Sep / Wid
Street address:		Date of Birth: (DD/MMM/YYYY - -			Email Address:
Home phone no.: ( ) -	City:		Province:		Post Code:
Occupation:	Employer:				Employer phone no.: ( ) -

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr. ☐ Chiropractor ☐ Massage Therapist ☐ Clinic ☐ Hospital

☐ Family ☐ Friend ☐ Location ☐ Plaza ☐ Yellow Pages ☐ Web Site ☐ Internet ☐ Sign ☐ Other

Other family members seen here:

WORKERS COMPENSATION (WSIB) (ONLY IF APPLICABLE)

☐ WSIB Injury Date of Accident: dd /mm /yy Claim Number: SIN#:

Occupation:	Employer:	Employer address:	Employer phone no.: ( ) -
Time off work? ☐ Yes ☐ No	How Long?		Contact at Work:
Description of Accident?			

AUTO INSURANCE & INSURANCE INFORMATION (ONLY IF APPLICABLE)

Date of Accident: dd /mm /yy	Claim Number:	Adjuster Name:
Did you require medical attention?: ☐ Y ☐ N	Did you require an ambulance?: ☐ Y ☐ N	Did you have x-rays?: ☐ Y ☐ N

Please indicate primary insurance:

Subscriber's name:	Social Insurance. No.: - -	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Description of Accident:					

CONSENT AND VERIFICATION

The above information is true to the best of my knowledge. I authorize my insurance benefits where applicable be paid directly to Active Therapeutic Solutions. I understand that I am financially responsible for any balance not paid by my insurer or WSIB in circumstances whereby the claim has been rejected. I also authorize Active Therapeutic Solutions to release any information required to process my claims to my insurer or the WSIB.

I acknowledge and agree that I am aware of the **24 hr cancellation policy** of Active Therapeutic Solutions and sign consent to the **full billing rate** of that missed treatment session. Extenuating circumstances are exempt. **Missed appointments** are not covered by insurance benefit or WSIB and must be paid by the **patient/client.**

Patient/Guardian signature

/ /
Date dd/mmm/yyyy

ACTIVE
Active Therapeutic Solutions

Original Date:
Dates Revised:

REGISTERED MASSAGE THERAPY
HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record

Name: Last:	First	MI	**DOB** (dd/mm/yyyy)	**Age:**

Type of Care Management: ☐Acute Relief Care ☐Maintenance/Supportive Care ☐Relaxation

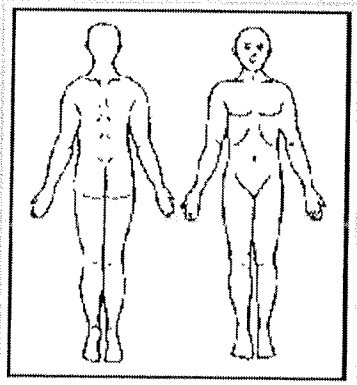
Family Doctor:	**Dr.'s Address:**
Date of Last Physical Exam:	**Doctor's Phone Number:**

PERSONAL HEALTH HSITORY

Current Complaint:				
When did it occur?				
Have you had this before?				
What was the cause?				
Where do you feel it most?				
Aggravations?				
Pain at night?				
Associated Symptoms?				
Character of Pain:	☐Sharp	☐Constant	☐Burning	☐Improving
	☐Shooting	☐Intermittent	☐Pins & Needles	☐Worsening
	☐Ache	☐Night Pain/Wakes from Sleep	☐Numb	☐Same since onset

(Therapist Use Only)
Analog Pain Level: Least ☐1☐2☐3☐4☐5☐6☐7☐8☐9☐10 Worst

Therapists Notes/Orthopaedic Findings:



Please outline on the diagram the area of your discomfort and any radiation of pain.

Other Doctor's or Therapist's seen for this condition:		
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name of Drug	**Strength**	**Frequency Taken**

List any Surgeries or Procedures		
Year	**Reason**	**Hospital**

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL		
Exercise	☐ Sedentary (No exercise)	
	☐Mild Exercise (i.e. climb stairs, walk 3 blocks, golf)	
	☐Occasional vigorous exercise (i.e. work or recreation, less than 4x/week for 30 min)	
	☐Regular vigorous exercise (i.e. work or recreation 4x/week for 30min)	
Is stress a major problem for you?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had any symptoms in the following areas to a significant degree and briefly explain.		
☐ Cough	☐ Deafness	☐ Pregnant Due Date:
☐ Shortness of Breath	☐ Vision Loss	☐ Neck Pain
☐ Bronchitis	☐ Loss of Sensation	☐ Upper Back Pain
☐ Asthma	☐ Diabetes	☐ Mid-Back Pain
☐ High Blood Pressure	☐ Epilepsy	☐ Shoulder Pain
☐ Low Blood Pressure	☐ Arthritis	☐ Arm Pain
☐ History of Heart Attack	☐ Cancer	☐ Leg Pain
☐ History of Stroke	☐ Osteoporosis	☐ Knee Pain
☐ Pace Maker	☐ Hepatitis	☐ Elbow pain
☐ COAD	☐ Tuberculosis	☐ Ability to Sleep
☐ Skin Allergies/Irritations	☐ AIDS/HIV	☐ Scoliosis
☐ SARS	☐ Other Pain/Discomfort:	☐ Artificial Joints/Pins

(Therapist Use Only)
Therapist Notes:

Treatment Plan:

Referral:

Extended Health Benefit Information

PRIMARY COVERAGE:

Patient Name: _____ Date of Birth: _____
DD/MM/YYYY

Insurance Company: _____

Policy Holder Name: _____ Date of Birth: _____
DD/MM/YYYY

Plan Number: _____ Certificate/Contract ID: _____

SECONDARY COVERAGE:

Insurance Company: _____

Policy Holder Name: _____ Date of Birth: _____
DD/MM/YYYY

Plan Number: _____ Certificate/Contract ID: _____

	Coverage Year	Amount of coverage per year	Coverage %	Amount of coverage per visit	Doctor Referral	Deductible
Chiropractic						
Physiotherapy						
Massage Therapy						
Orthotics						
Health Spending Account						
Acupuncture						

Additional Orthotic Coverage Questions:

Can the orthotics be dispensed by a chiropractor? ☐ YES ☐ NO

Are there any other requirements? ☐ YES ☐ NO

If yes, please describe: _____

_____