BC BACK CLINIC
Unit 102–15150 No.10 Highway
Surrey, BC V3S 1B8
T: 778.574.4999 • F: 778.574.4909
www.bcback.ca

Client Intake Form

NAME: _____ BIRTH DATE: _____ (MM/DD/YY) SEX: M / F

ADDRESS: _____

CITY: _____ POSTAL CODE: _____

CARE CARD #: _____ EMAIL: _____

PHONE: _____ WORK: _____ CELL: _____

EMERGENCY CONTACT: _____ RELATION: _____ PHONE: _____

DOCTOR'S NAME: _____ PHONE: _____

How did you hear about us?: ☐ Internet ☐ Clinic Signage ☐ Yellow Pages ☐ Friend/Co-worker ☐ Doctor/Lawyer

Please note that you will be charged the appointment fee for any appointments cancelled without 24 hours notice

☐ **(please initial to acknowledge that you have read the above statement regarding our cancellation policy)**

EMPLOYER: _____

ADDRESS: _____

CITY: _____ POSTAL CODE: _____

EMPLOYER'S PHONE: _____

OCCUPATION: _____

JOB AVAILABLE ON DISCHARGE: YES NO

DATE OF INJURY: _____ (MM/DD/YY) CLAIM #: _____

TYPE OF INJURY: _____

START DATE IN THE PROGRAM: _____

ADJUSTERS NAME: _____ OFFICE: _____

BC BACK CLINIC
Unit 102–15150 No.10 Highway
Surrey, BC V3S 1B8
T: 778.574.4999 • F: 778.574.4909
www.bcback.ca

CONSENT FOR EXAMINATION, TREATMENT AND RELEASE OF PATIENT INFORMATION

I, the undersigned, do hereby consent to examination/treatment at BC Back Institute, which may include aerobic exercises, strengthening exercises and flexibility exercises.

I also authorize BC Back Institute to release medical information to physicians, I.C.B.C., Lawyers, and/or Insurance Companies that are directly involved with my care. I further authorize BC Back Institute to obtain medical records regarding my condition. Furthermore, I authorize BC Back Institute to contact my employer(s) to discuss return to work options.

Program expectations have been explained to me and I fully understand that failure to comply with the following may result in I.C.B.C. Notification and possible program termination.

If I am not able to attend a scheduled appointment, 24-hour cancellation notice is required and I must contact the BC Back Institute. I understand if I fail to attend three scheduled appointments without sufficient notice, a valid reason, or a supported medical reason I may be discharged from the program.

I must report any doctor visits and other therapy visits to my therapist to allow for optimal communication regarding my progress

I will be provided with an independent stretching program and am expected to complete the stretches daily- An exercise sheet will be given to me to take home.

I am to attend the gym independently if recommended by my therapist.

I understand and agree to the above.

DATED THIS: _____ DAY OF: _____ (month) YEAR: _____

PATIENT: _____ WITNESS: _____

SIGNATURE: _____ SIGNATURE: _____

BC BACK CLINIC
Unit 102–15150 No.10 Highway
Surrey, BC V3S 1B8
T: 778.574.4999 • F: 778.574.4909
www.bcback.ca

MEDICAL HISTORY / LIABILITY FORM

PAST HISTORY

HAVE YOU EVER HAD?

- ☐ *Heart murmur*
- ☐ *High blood pressure*
- ☐ *Rheumatic fever*
- ☐ *Any heart trouble*
- ☐ *Disease* of *arteries*
- ☐ *Lung disease*
- ☐ *Injuries* of *back, etc*
- ☐ *Epilepsy*
- ☐ *Severe dizzy spells*
- ☐ *Diabetes*

PRESENT SYMPTOMS

HAVE YOU RECENTLY HAD?

- ☐ *Chest pains*
- ☐ *Shortness* of *breath*
- ☐ *Heart palpitations*
- ☐ *Cough on exertion*
- ☐ *Coughing* of *blood*
- ☐ *Back pain*
- ☐ *Swollen, stiff or painful joints*
- ☐ *Muscle or tendon injury*
- ☐ *Major surgery*
- ☐ *Other*

Please explain other: _____

_____

_____

LIABILITY / INFORMED CONSENT

1. *The medical history questions are answered to the best of my knowledge. I understand and am aware that strength, flexibility, and aerobic exercise, including the use of equipment,* is a *potentially hazardous activity. I also understand that fitness activities involve* a *risk of injury and even death, and that I* am *voluntarily participating in these activities and using equipment and machinery with knowledge of the dangers involved. I hereby agree to expressly assume and accept any and all risks of injury or death.*
   PLEASE INITIAL_____

2. *I hereby waive any and all claims that I have or may* in *the future have against BC Back Institute, its directors, officers, and employees from any and all liability for any loss, damage, injury or expense that I may suffer, or that my next of kin may suffer.*
   PLEASE INITIAL_____

I hereby affirm that I have read and fully understand the above.

SIGNATURE: _____ DATE: _____