HYDROACTIVE
AQUATHERAPY & REHABILITATION

APPLICATION FOR CARE

DATE: _____

LAST NAME:	**FIRST NAME:**	**MIDDLE NAME:**
STREET ADDRESS:		
CITY:	**PROVINCE:**	**POSTAL CODE:**
HOME TEL:	**MOBILE:** Can we leave confidential voicemail? Yes / No	
EMAIL ADDRESS:	**OCCUPATION:**	
DATE OF BIRTH (YYYY/MM/DD):	**GENDER:** ❑ MALE ❑ FEMALE	
MARITAL STATUS:	**NUMBER OF CHILDREN:**	**AGES OF CHILDREN:**
HAVE YOU HAD PREVIOUS CHIROPRACTIC OR PHYSIOTHERAPY CARE: ❑YES ❑NO		**CLINIC NAME:**
DO YOU HAVE EXTENDED HEALTH INSURANCE: ❑ YES ❑NO		**NAME OF INSURANCE COMP.:**
GROUP/POLICY #:		**ID/CERTIFICATE #:**
POLICY HOLDER:		**POLICY HOLDER DATE OF BIRTH:**
FAMILY DOCTOR'S NAME:		**FAMILY DOCTOR'S TELEPHONE:**
HOW DID YOU HEAR ABOUT US:		
NAME & NUMBER OF EMERGENCY CONTACT:		**RELATIONSHIP:**
Do we have your permission to leave personal medical information with your emergency contact? Yes / No		

T: 905-879-1251
E: info@hydroactive.ca

676 Westburne Drive, Unit 1
Concord, ON L4K 4V5

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HISTORY of COMPLAINT

Please identify what brought you into our office today: ***(i.e. What areas do you need help/assistance with)***

Primary: _____ Secondary: _____

Third: _____ Fourth: _____

Is your problem the result of ANY type of accident? ❑Yes ❑No

Did you receive treatment in the past for this condition? ❑Yes ❑No

PAST HISTORY

Have you ever had any of the following? When?	**DID YOU GET CHECKED?**
INJURIES (slip/fall, car accidents, sport injury) If yes, please explain _____	❑ Yes ❑ No
SURGERIES If yes, what type _____	❑ Yes ❑ No
CHILDHOOD DISEASES If yes, which one(s)	❑ Yes ❑ No
ADULT DISEASES If yes, which one(s)	❑ Yes ❑ No

Any other hereditary conditions the doctor should be aware of? ❑ Yes ❑No

_____

_____

MEDICATIONS

List Prescription and Non-prescription drugs you take (including dosage)

_____

_____

_____

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PLEASE INDICATE IF YOU HAVE EVER EXPERIENCED ANY OF THE FOLLOWIG CONDITIONS:

Indicate P for Past, C for Current.

- ___ Broken Bone
- ___ Heart Attack
- ___ Headache
- ___ Neck Pain
- ___ Jaw Pain, TMJ
- ___ Shoulder Pain
- ___ Upper Back Pain
- ___ Mid Back Pain
- ___ Low Back Pain
- ___ Hip Pain
- ___ Poor Posture
- ___ Scoliosis
- ___ Tumors
- ___ Diabetes
- ___ Dizziness
- ___ Loss of Balance
- ___ Fainting
- ___ Double Vision
- ___ Cancer
- ___ Swellings around ankles/feet
- ___ Varicose Veins
- ___ Osteopenia
- ___ Osteoarthritis
- ___ Immune system issues
- ___ Frequent colds/flu
- ___ Convulsions/Epilepsy
- ___ Tremors
- ___ Chest Pain
- ___ Pain with cough/sneeze
- ___ Foot or Knee problems
- ___ Swollen/Painful Joints
- ___ Skin Problems
- ___ Blurred Vision
- ___ Ringing in Ears
- ___ Hearing Loss
- ___ Depression
- ___ Irritable
- ___ Chronic Fatigue
- ___ Mood Changes
- ___ ADD/ADHD
- ___ Allergies
- ___ Rheumatoid Arthritis
- ___ Cerebral Vascular
- ___ Prostate Problems
- ___ Impotence/Sexual Dysfunction
- ___ Digestive Troubles
- ___ Diarrhea/ Constipation
- ___ Menopausal Problems
- ___ Menstrual Problems
- ___ PMS
- ___ Bed Wetting/Bladder issues
- ___ Learning Disability
- ___ Eating Disorder
- ___ Trouble Sleeping
- ___ HIV/AIDS
- ___ Ulcers
- ___ Heartburn
- ___ Heart problems
- ___ High/Low blood pressure (Circle)
- ___ High Cholesterol
- ___ Asthma
- ___ Difficulty Breathing
- ___ Lung Problems
- ___ Kidney Problems
- ___ Gall Bladder Trouble
- ___ Liver Trouble
- ___ Hepatitis (A, B, C)
- ___ Sleep Difficulties
- ___ Numb/Tingling/Pain Into legs, feet, toes
- ___ Numb/Tingling/Pain Into arms, hands, fingers
- ___ Osteoporosis
- ___ Dislocations

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GOALS FOR CARE

What is the purpose of your decision to seek care?

❑ Pain Relief ❑ Stress Reduction ❑ Improved General Health and Well Being
❑ Improved Posture ❑ Spinal Correction ❑ Weight Loss
❑ Other _____

WHAT TYPE OF SERVICES AND PRODUCTS ARE YOU INTERESTED IN

SERVICES AND PRODUCTS OFFERED AT HYDROACTIVE

❑ Aqua Therapy ❑ Chiropractic Care ❑ Massage Therapy
❑ Concussion Therapy ❑ Spinal Correction ❑ Home Exercise Program
❑ Custom Orthotics ❑ Compression Stockings ❑ Tens Unit
❑ Psychotherapy ❑ Supplements

REGARDING: X-rays/Imaging Studies

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

❑ The first day of my last menstrual cycle was on _____

❑ I have been provided with a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By signing below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

PATIENT NAME

PATIENT SIGNATURE

DATE

WITNESS NAME (Print Name) AND SIGNATURE

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BY SIGNING THIS DOCUMENT, YOU WILL WAIVE CERTAIN LEGAL RIGHTS, INCLUDING THE RIGHT TO SUE OR CLAIM COMPENSATION FOLLOWING AN ACCIDENT

PLEASE READ CAREFULLY

TO: HYDROACTIVE AQUATHERAPY & REHABILITATION INC. and its directors, officers, employees, instructors, guides, agents, representatives, independent contractors, subcontractors, suppliers, hosts, volunteers, successors and assigns (all of whom are hereinafter referred to as the "**OPERATOR**")

Name	Last	First	Initial
Address	Street		
	City	Province	Postal Code
Date of Birth			

ASSUMPTION OF RISKS

I am aware that the participation in the activities conducted by the OPERATOR (the "Activity"), use of the Activity equipment (the "Equipment") and attendance at the facilities where the Activity takes place (the "Facilities") involves many risks, dangers and hazards including, but not limited to: mechanical failure of Equipment or Facilities; postural stress; insufficient physical condition, fitness, or abilities; negligence of you or other participants; other undefined harm which or damage which is not readily foreseeable and other presently unknown risks or dangers; and **NEGLIGENCE ON THE PART OF THE OPERATOR. I UNDERTAND THAT NEGLIGENCE INCLUDES FAILURE ON THE PART OF THE OPERATOR TO TAKE REASONABLE STEPS TO SAFEGUARD OR PROTECT ME FROM THE RISKS, DANGERS AND HAZARDS OF THE ACTIVITY.**

I AM AWARE OF THE RISKS, DANGERS AND HAZARDS ASSOCIATED WITH THE ACTIVITY, AND I FREELY ACCEPT AND FULLY ASSUME ALL SUCH RISKS, DANGERS AND HAZARDS, AND THE POSSIBILITY OF PERSONAL INJURY, DEATH, PROPERTY DAMAGE AND LOSS RESULTING THEREFROM.

RELEASE OF LIABILITY, WAIVER OF CLAIMS, INDEMNITY AND IMAGE RIGHTS ASSIGNMENT AGREEMENT

In consideration of the OPERATOR accepting my application for participation in the Activity, and permitting my use of the Equipment and the Facilities, I hereby agree as follows:

1. **TO WAIVE ANY AND ALL CLAIMS** that I may have in the future, against the **OPERATOR AND TO RELEASE THE OPERATOR** from any and all liability for any loss, damage, expense or injury including death that I or my next of kin may suffer, resulting from either my use of or my participation in the Activity, use of the Equipment, presence on the Facilities, or travel outside the Facilities, **DUE TO ANY CAUSE WHATSOEVER, INCLUDING USE OF THE IMAGES (AS HEREINAFTER DEFINED), NEGLIGENCE, BREACH OF CONTRACT, OR BREACH OF ANY STATUTORY OR OTHER DUTY OF CARE OWED UNDER ANY APPLICABLE OCCUPIERS' LIABILITY LEGISLATION ON THE PART OF THE OPERATOR. I UNDERSTAND THAT NEGLIGENCE INCLUDES FAILURE ON THE PART OF THE OPERATOR TO TAKE REASONABLE STEPS TO SAFEGUARD OR PROTECT ME FROM RISKS, DANGERS AND HAZARDS REFERRED TO ABOVE;**
2. **TO HOLD HARMLESS AND INDEMNIFY THE OPERATOR** from any and all liability for any damage to property of, or personal injury to, any person or entity resulting from my participation in the Activity, use of the Equipment, presence on the Facilities, or travel outside the Facilities;
3. To follow and obey the rules and regulations provided by OPERATOR at all times during my participation in the Activity.
4. The terms of this release of this Agreement relating to waiver and indemnity shall survive termination of this Agreement. This Agreement shall be binding upon my heirs, next of kin, executors, administrators, assigns and representatives in the event of my death or incapacity. Any litigation involving the parties to this Agreement shall be brought solely within the Province of Ontario and shall be within the exclusive jurisdiction of the Courts of the Province of Ontario and governed by the laws thereof; and in entering into this Agreement, **I AM NOT RELYING UPON ANY ORAL OR WRITTEN REPRESENTATIONS OR STATEMENTS MADE BY OPERATOR** with respect to the safety of the Activity other than what is set forth in this Agreement. Should any provision in this Agreement be deemed invalid or unenforceable by a court of competent jurisdiction, such provision will only be ineffective to the extent of that restriction and all remaining provisions or parts thereof shall remain in full force and effect.

I CONFIRM THAT I HAVE READ THIS AGREEMENT AND UNDERSTAND, AND AM AWARE THAT BY SIGNING THIS AGREEMENT I AM WAIVING CERTAIN LEGAL RIGHTS WHICH I OR MY HEIRS, NEXT OF KIN, EXECUTORS, ADMINSITRATORS, ASSIGNS AND REPRESENTATIVES MAY HAVE AGAINST THE OPERATOR. I REPRESENT THAT I AM AT LEAST 18 YEARS OF AGE. I FURTHER REPRESENT THAT THERE IS NO MEDICAL OR PHYSICAL REASON WHY PARTICIPATION BY MYSELF COULD BE POTENTIALLY HARMFUL IN ANY WAY.

Signed this _____ day of _____, 20_____.

PRINTED NAME _____ **SIGNATURE** _____

WITNESS NAME _____ **WITNESS SIGNATURE** _____

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RESCHEDULING POLICY

Due to the limits on scheduling capacity, when patients cancel or miss appointments without providing sufficient notice, they prevent other patients from being seen for necessary care.

Providing our patients with exceptional care is of upmost importance to us at **Hydroactive Aquatherapy & Rehabilitation**, with these new changes in place we hope to better accommodate our patients needs.

Should you need to reschedule your appointments, please contact our office at 416-897-9792 or 905-879-1251 no later than 48 HOURS prior to your scheduled appointment.

If sufficient notification is not provided, you will be charged THE TOTAL COST FOR THE SERVICE/SERVICES scheduled on that day.

We appreciate your anticipated understanding and cooperation concerning this matter. We are committed to offering you excellent service and care.

Dated at _____ (CITY), this _____ day of _____, 20___

Patient Name_____ Signature_____

Witness Name_____ Signature_____

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CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____ hereby consent to and authorize the release of my medical information to my rehabilitation clinic, Hydroactive Aquatherapy & Rehabilitation. Please fax my medical information to **905-884-2968**.

Medical Information Requested:

- X-ray Reports
- Ultrasound Reports
- MRI/CT scan Reports
- Other_____

_____
SIGNATURE

_____
DATE

_____
DATE OF BIRTH

_____

HEALTH CARD NUMBER

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