quinnrehab
Trusted Health Professionals Since 1994
505 - 34 Cedar Pointe Drive
Barrie, ON L4N 5R7
phone: 705-726-2362 fax: 705-726-1589

RELEASE OF INFORMATION CONSENT FORM

I, _____ **authorize QuinnRehab**
Print Patient / Guardian Name

to furnish or obtain all information from (please list family doctor/surgeon/specialist)

_____

including any documents and reports in regards to the condition and treatment of:

_____ _____
Print Patient Name **Date of Birth: yyyy / mm / dd**

_____ _____
Patient / Guardian Signature **Date: yy yy / mm / dd**

_____
Patient / Guardian Name (please print)

_____ _____
Witness Signature **Date: yy yy / mm / dd**

_____
Witness Name (please print)

Returning for treatment - signature update

By signing below, you indicate your continued agreement within the terms of this document.

Update #1: _____ _____ _____
Patient / Guardian Signature | Date: yy /mm / dd | Witness Signature

Update#2: _____ _____ _____
Patient / Guardian Signature | Date: yy /mm / dd | Witness Signature

CONFIDENTIAL PATIENT INFORMATION

(protected by law when complete)

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Date: _____
yyyy mm dd

_____
Name, if different than Legal Name (Optional)

_____ _____
Legal First Name Legal Last Name

_____ _____
Street Name / P.O. Box Apartment / Unit #

_____ _____
City Province Postal Code

GENDER: _____ (Optional) **PRONOUNS:** _____ (Optional)

BIRTHDATE: _____ (Year / Month / Day) **EMAIL:** _____ (will be used only with consent)

TELEPHONE : Home _____
Business _____ EXTENSION # _____
Cell _____

OCCUPATION: _____

HOBBIES: _____

MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO **DATE OF ACCIDENT?** _____ YY / MM / DD

WORK RELATED INJURY? ☐ YES ☐ NO **DATE OF INJURY?** _____ YY / MM / DD

OTHER: _____ (PLEASE SPECIFY)

MEDICAL HISTORY

Treatment area? _____

When did your problem begin ? _____

Other Problems / Complaints _____

What activities are affected by your pain/problem/injury? _____

HAVE X-RAYS, SCANS OR MRI'S BEEN TAKEN? ☐ YES ☐ NO **Where?** _____

Emergency Contact (optional) _____
(Phone number)

INDICATE OTHER CONDITIONS:

Pregnancy	☐	Cancer	☐	Allergies	☐
Heart Disease / Pace Maker	☐	Surgeries / Pins & Plates	☐	Depression	☐
Blood Pressure Problems	☐	Dental / Jaw Problems	☐	Thyroid	☐
Diabetes	☐	Headaches / Dizziness	☐	Other:	☐
Shortness of Breath / Asthma	☐	Loss of Balance	☐	_____	
Arthritis	☐	Neck / Back / Shoulder Pain	☐	_____	

SIGNATURE: _____