STRATFORD HAND THERAPY
Hand and Upper Limb Rehabilitation

Client Intake and Informed Consent Form

Client Information	
Name:	**Date of Birth (DD/MM/YYY):**
Address:	**Hand Dominance** (Please circle): Right Left
Phone Number (Home/Cell):	**Email Address:**
Your Job or Valued Activities & Roles:	
Contact Person & Phone Number (in case of emergency):	**Your Social Supports:**

Insurance Information	
□ **Private Pay**	
□ **WSIB**	**WSIB Claim #**
□ **Extended Health**	**Insurance Company** (please check to ensure Occupational Therapy services and custom made orthotics are covered)

Your Hand and Upper Limb Injury, Surgery or Concerns
Date of Injury, Surgery or Onset:
For Injuries, what happened?:
What are your current concerns?
What are you currently using to manage your concerns? (ie. medications, icing, rest)
What therapies/treatments have you participated in so far?

Your Pertinent Medical History

Please circle any of the following medical conditions that apply to you:
Allergies Anxiety Cancer Cardiac Problems Depression Diabetes Dizziness/Fainting Falls Fractures Hepatitis/HIV Infectious Disease Insomnia Osteoarthritis Osteoporosis Pacemaker Respiratory Problems Rheumatoid Arthritis Seizures Stroke Substance Abuse
Any other pertinent medical problems?_____

Have you had a previous hand or upper limb injury or condition? ☐ **Yes** ☐ **No**

Your Hand Therapy Goals

Please provide **up to 3 important activities** that you are unable to do or are having difficulty with as a result of you hand and upper limb injury or condition. **Rate your current ability to perform your valued activity** with the following scale:

0 1 2 3 4 5 6 7 8 9 10
Unable to perform — Able to perform activity at the same level as before injury or problem

Activity 1	Rating (0-10)
Activity 2	Rating (0-10)
Activity 3	Rating (0-10)

Consent to Treatment and Commitment to Privacy

To be signed, in the presence of your therapist, at your first Hand Therapy appointment
I understand the Occupational Therapist is providing assessments and treatments within the scope of practice as defined by the College of Occupational Therapists of Ontario. I hereby consent to my Occupational Therapist to treat me within the scope of practice. I allow photographs of my hands to be taken for monitoring and education purposes.
I understand the protection of the privacy and confidentiality of my information is important to Stratford Hand Therapy (SHT). I agree that SHT may provide clinical information regarding this injury and therapy progress to my referring and/or family physician and when requested, with WSIB or my insurance company. I understand that I am financially responsible for all charges, whether covered by my extended insurance plan or not. I understand that SHT service fees are payable at the time of the appointment. I understand that custom-made orthotics are not refundable. I understand that, where possible, SHT would like 12 business hours notice, if there is a need to reschedule or cancel an appointment. If I do not show up for a scheduled appointment, a $40 no show fee will apply.

Client Signature	**Date**	Therapists Initials