SUMMIT sport physiotherapy

NEW PATIENT INFORMATION FORM

Welcome, thank you for choosing Summit Sport Physiotherapy. We look forward to assisting you with your needs and recovery.

In order to provide you with the most effective and efficient treatment we ask that you take the time to answer these questions as an investment in your recovery. All of your information will be kept confidential and secure in accordance with the Health Information Act. (HIA)

NAME:_____
(Last) (First)

MAILING ADDRESS:_____

CITY/TOWN:_____ POSTAL CODE:_____

HOME PHONE:_____ CELL PHONE:_____ OTHER:_____

E-MAIL ADDRESS:_____

DATE OF BIRTH: M/_____ D/_____Y/_____ M □ F □

EMERGENCY CONTACT: _____ PHONE: _____

Alberta Health Care #:_____

Family Physician / Surgeon:_____ Phone:_____

Who Referred You For Treatment?:_____

I UNDERSTAND REGARDING FUNDING FOR MY CARE:

□ **I am ultimately responsible for the cost of my care here at Summit**

□ **Blue Cross, asebp and MVA claims can be direct billed but it is up to me to speak to the receptionist regarding these services and follow the appropriate rules for these services to be provided.**

□ **Alberta Health Services funding is only available following recent surgery , recent fracture (12 weeks) or for those with documented low income. Please inquire with reception if these may apply .**

□ **There will be a charge for missed appointments or frequent cancellations with less than 24 hours notice.**

I CONSENT TO PHYSICAL THERAPY including: (Please Check Boxes)

□ **ASSESSMENT** WHICH MAY INVOLVE THE PHYSIOTHERAPIST ASKING YOU QUESTIONS, OBSERVING YOUR MOVEMENT AND POSTURE, MEASURUNG YOUR JOINT RANGE OF MOTION AND MUSCLE STRENGTH, ASSESSING YOUR NERVOUS AND VASCULAR SYSTEM. YOU ARE FREE TO ASK QUESTIONS DURING THE ASSESSMENT AND UNDERSTAND THAT YOU CAN STOP THE ASSESSMENT AT ANY POINT.

□ **TREATMENT** THAT MAY INCLUDE SOFT TISSUE WORK, MANUAL THEAPY, SPINAL MANIPULATION, ELECTROTHERAPEUTIC MODALITIES, THERMAL MODALITIES, ACCUPUNCTURE, INTERMUSCULAR STIMULATION, EXERCISE, TAPING AND EDUCATION. YOUR THREAPIST WILL EXPLAIN TO YOU THE POTENTIAL BENEFITS, SIDE EFFECTS AND RISK ASSOCIATED WITH EACH TREATMENT TECHNIQUE PRIOR TO USE. YOU ARE FREE TO ASK QUESTIONS AT ANY TIME BEFORE, DURING AND AFTER YOUR TREATMENT(S). **YOU MAY STOP TREATMENT AND/OR SUBSEQUENT TREATMENTS AT ANY TIME.**

SIGNATURE:_____ DATE:_ _____

If you are **UNDER 18** years of age, please give us the name and contact information of Guardian. * They will also need to sign this form.

Guardian:_____ Relationship:_____

Address:_____ Phone Number:_____

Signature:_____

PLEASE DESCRIBE THE PROBLEM WHICH YOU ARE SEEKING TREATMENT TODAY:_____

_____

IS YOUR VISIT DUE TO A RECENT SURGERY OR FRACTURE: YES ☐ NO ☐ DATE OF OCCURANCE:_____

ARE YOU SEEKING TREATMENT DUE TO INJURY AT WORK: YES ☐ NO ☐ (Please Inform us if this is a WCB Claim)

ARE YOU SEEKING TREATMENT DUE TO A RECENT MOTOR VEHICAL ACCIDENT: YES ☐ NO ☐ (Please provide insurance information)

Date Episode Started:_____ Have You Had This Issue Before: Y____ N____ When:_____

Duration of Episode: ____DAYS ____WEEKS ____MONTHS ____YEARS Onset: SLOW ☐ FAST ☐

Pain Rating Scale: 0 Being no pain – 10 Being unmanageable pain (circle one)

0 1 2 3 4 5 6 7 8 9 10

Pain Pattern: ____ Constant ____ Intermittent ____ Disturbs Sleep Has the Pain: ↑ ↓

Are you Using: ____ Ice ____ Heat ____ Rest ____ Medication List:_____

_____

_____

What Makes It Worse:_____

What Makes It Better:_____

What Do You Hope to Achieve From Your Visit Today: _____ Pain Relief _____ Diagnosis of Condition _____ Exercises

GENERAL HEALTH:

What is Your Current Stress Level: _____ None _____ Mild _____ Moderate _____ High _____ Severe

How Are You Feeling About Your General Health: (Circle all that apply)

Excellent Good Acceptable Concerned Very Concerned Frustrated Frightened Distressed

For this injury have you seen: _____ Family Physician _____ Chiropractor _____ Specialist (Name:_____)

_____ Massage Therapist _____Other (Name:_____)

Please supply us with phone number(s) for your specialist and other care provider(s):

Name: **Phone Number:**

DO YOU HAVE ANY OF THE FOLLOWING: Please Check All That Apply

- ☐ Currently pregnant
- ☐ Infectious Disease
- ☐ High blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Disease
- ☐ PACE MAKER
- ☐ Circulatory Disorder
- ☐ Bleeding Disorder
- ☐ On Blood Thinners
- ☐ Metal Implant
- ☐ Breast Implant
- ☐ Current Cancer
- ☐ Past Cancer
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Recent Hospitalization
- ☐ Recent Illness
- ☐ Urinary Issues
- ☐ History of Falls
- ☐ Recent Trauma
- ☐ Recent Hospital Stay
- ☐ Weight Changes ↑ ↓
- ☐ Epilepsy / Seizures
- ☐ Arthritis
- ☐ Osteoarthritis
- ☐ Current Smoker
- ☐ Asthma / Emphysema
- ☐ Drug Allergies
- ☐ HIV / AIDS/ HEP A,B,C
- ☐ Severe Headaches

Any additional information you would like to add: