SEXSMITH PHYSIOTHERAPY REGISTRATION FORM

PATIENT INFORMATION

Last Name:	First Name:	Middle Name:	❑ Mr.	❑ Miss
			❑ Mrs.	❑ Ms.

Preferred name:	Parent/Guardian name (if applicable):	Alberta Health Care number:	Birth date:	Age:

Address:	City:	Province:	Postal code:

Home phone number: ( )	Cell Phone number: ( )	Which phone number would be preferred during daytime hours?
Email address:		Note: Email will be used for scheduling reminders and clinic updates only
Occupation:	Employer:	Family Physician:
Do you have a benefit plan that includes physiotherapy or massage therapy? ❑Yes ❑No		Referring Physician:
Have you been to a physiotherapist or massage therapist before? ❑Yes ❑No		Have you been to this clinic before? ❑Yes ❑No

Chose clinic because/Referred to clinic by (please check):			❑ Dr.	❑ Specialist – Dr.		❑Hospital
❑ Family	❑ Friend	❑ Location	❑ Yellow Pages	❑ Lawyer	❑WCB	❑ Other

IN CASE OF EMERGENCY

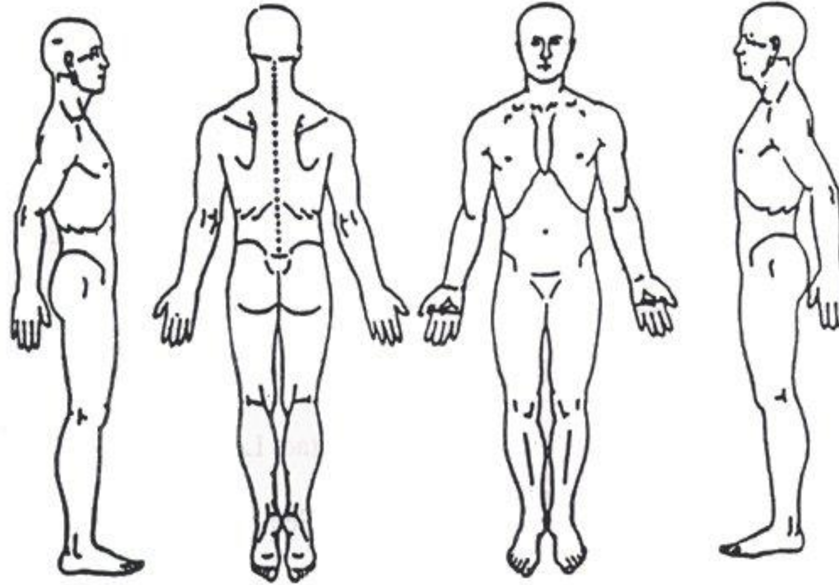
Name of emergency contact person:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

OTHER DETAILS

Is this injury a result of a motor vehicle collision? ❑Yes ❑No	Did this injury happen at work? ❑Yes ❑No
If yes, when did it occur?	If Yes, when did it occur?
Your vehicle insurance company?	Has it been reported?
Your insurance phone number	Is there a WCB file number?
Your insurance company address?	Have you missed work because of this injury?
Your Adjuster's name?	Are you back to work now?
Your claim number?	When did you first see a doctor for this injury?

HISTORY OF INJURY

Please indicate any areas that you feel pain/discomfort



What is the main problem? **When** did it start? **How** did it start?	What makes your problem **worse**? What makes your problem **better**? Have you had a problem like this before? ❑Yes ❑No
Is this problem getting ... ❑better ❑worse ❑not changing	What type of tests have you had for this problem? ❑X-rays ❑CT scan ❑MRI ❑Ultrasound ❑other

Is there any activities that you are having difficulty performing?
What are your goals for treatment?

MEDICAL HISTORY

Please indicate if you have or have had any of the following:

❑ heart problems	❑ poor circlation	❑ pacemaker or any type of implant	
❑ arthritis	❑ cancer or tumors	❑ digestive problems	
❑ blood disorders	❑ high blood pressure	❑ depression	
❑ spinal conditions	❑ low blood pressure	❑ allergies	
❑ stroke	❑ rheumatologic	❑ lung problems	
❑ heart attack	❑ anxiety	❑ diabetes	❑ other
❑ oteoporosis	❑ currently pregnant	❑ thyroid problems	

Please list **ANY** other injuries, surgeries or motor vehicle collisions you've ever had.

What medications are you taking? (please list all, including non-prescription)

Are you being treated by any other health professionals?	❑Physical Therapist	❑Chiropractor	❑Other
	❑Massage Therapist	❑Acupuncturist	

Do you exercise? What type of exercise? How often?	Any other activities and hobbies?

Patient signature (or Authorized Representative)

Today`s Date

PATIENT CONSENT FORM

Thank you for choosing Sexsmith Physiotherapy. The best health services are based on a friendly, mutual understanding between provider and patient. We want you to be able achieve your goals as quickly and as safely as possible. Your active participation is required for the best possible outcomes. You have the right to refuse treatment at any time. You have the right to ask questions.

All information that you provide will be kept confidential, and information will only be provided to third parties with your written consent.

Our policy requires payment in full for all services rendered at the time of visit. Please be aware that you will be financially responsible for any balance. There will be a $25.00 fee for NSF cheques.

During your physiotherapy or massage therapy visit, it is often necessary to expose and touch the area in need of treatment. Every effort is made to preserve modesty and keep you comfortable. Please communicate to your therapist if you have any concerns during the treatment.

For Physiotherapy Clients: Your initial assessment will include a physical examination of the problem area, nearby muscles and joints, and a screening exam including the nervous system of the neck and/or lower back. Your Physical Therapist will discuss findings of the assessment including the main cause and contributing factors to the problem, suggested treatment plan, appointment timing and funding.

For Massage therapy clients: Your Massage Therapists DOES NOT diagnose illness, disease, or any other physical or mental disorder. Massage therapy is not a substitute for medical examination and/or diagnosis.

Cancellation/Missed Appointment Policy for all clients

When you are unable to make a scheduled appointment we require 24 hours notice. This allows us to attempt to fill your appointment time with someone else who is waiting. Please call the clinic and leave a message on voicemail or send an email if you are unable to reach anyone during business hours. Failure to give appropriate notification will result in a $20.00 charge. **Please sign to indicate that you understand the above policies, or ask for clarification if needed.**

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Signature

Consent to Electronic communication

We want to be in compliance with the Canada Anti-SPAM Act. This legislation demands that we have consent to send electronic messages to you. The messages that we send from Sexsmith Physiotherapy include:

- appointment reminders,
- birthday greetings,
- clinic updates,
- exercise instructions,
- discharge notices,
- and account statements.

If you would like to receive these messages, please sign and date below. Thank you.

Signature	Email address	Date