CONCORDIA
PHYSIO SPORT

Patient Information Form

Last Name:________________ First Name:________________ Medicare #:________________

Maiden Name (if applic.): ________________ Date of Birth: ___ / ___ / ___ Age: ________________
M D Y

Address:________________ City: ________________ Postal Code:________________

Telephone (home):(____) ________________ Work: (____) ________________ Ext: ________________

Cell: (____)________________ Email: ________________

E-MAIL NOTIFICATION
I agree to receive e-mail notifications regarding the following: appointment reminders/scheduling changes, newsletters, educational materials/injury prevention information and information on our services. I understand that I may opt out at any time by unsubscribing or by informing CBI that I no longer wish to receive e-mail notifications. ☐ Check box to opt in Initials: _________
I understand that upon receiving any of the above e-mail notifications, I will have the opportunity to unsubscribe from future emails at any time.

Occupation: ________________ Employer:________________

Reason for today's consultation: ________________

Family Physician: ________________ Last check-up: ________________

Person to contact in case of emergency: Name: ________________ Tel Number:________________

Is your injury related to an automobile accident or a workplace accident? Yes ______ No ______

Date of Accident: ________________ SAAQ Dossier #: ________________

CSST Dossier #: ________________

How did you hear about our clinic? Please specify a name where appropriate.

Doctor: ________________ Former / Current Patient: ________________

Therapist: ________________ Advertisement / Publicity: ________________

Web Site / Web search: ☐ You are a returning patient: ☐ Other ________________ ☐

In order to offer all of our clients exceptional service, please read the following and sign to indicate your consent:

1) We require at least 24 hours notice for any cancelled appointments. Should you be unable to provide us with at least 24 hours notice before your scheduled appointment, you will be charged $35.00 (these fees are not refundable by the SAAQ or by your private insurance). By signing below, you acknowledge the cancellation policy and agree to pay any fees associated with missed appointments or late cancellations.
2) Please arrive 10 minutes prior to your scheduled evaluation time, and 5 minutes prior to your scheduled treatment time. In order to maintain a quality service, late arrivals may result in a reduction of your session length.
3) Our clinics have a locker room and washroom available for your convenience. Please bring a lock if you plan to use a locker.
4) All receipts will be issued only to the individual treated / evaluated, in their name, for the service / professional seen, for the dates and exact prices of the provided treatments. No exceptions will be made to this policy.

Signature ________________________________ Date ________________

Medical Information

Last Name: ______________________ First Name: ____________________

Telephone: (____) ______________ Email: ____________________________

In order to better guide your evaluation and treatment planning, please complete the following questionnaire regarding your health. If there are any answers that you are unsure of, your therapist will go through them with you.

Are you presently being treated by another health professional? Yes ❒ No ❒

For what reason(s)? ________________________________ Profession: __________________

	Yes	No	Details
Are you pregnant?	❒	❒	____________

Pregnancies and deliveries (number and year) ____

Have you ever suffered from or do you currently suffer from the following conditions?

	Yes	No	
Diabetes or other endocrine problems	❒	❒	____________
Arthritis	❒	❒	____________
Steroid Use (including cortisone)	❒	❒	____________
Digestive problems	❒	❒	____________
Neurological problems	❒	❒	____________
Cancer	❒	❒	____________
Headaches	❒	❒	____________
Insomnia	❒	❒	____________
Orthopaedic problems (including fractures, sprains, strains, dislocations)	❒	❒	____________
Major traumas (accidents, falls)	❒	❒	____________
Osteoporosis	❒	❒	____________
Inflammatory illness (ex.: rheumatoid arthritis)	❒	❒	____________
Major infections	❒	❒	____________
Cardiac problems (ex.: hypertension, angina, stroke, cholesterol)	❒	❒	____________
Respiratory problems (ex: asthma, emphysema)	❒	❒	____________
Do you currently have or have you recently had a fever?	❒	❒	____________
Have you lost significant weight in the last 6 months?	❒	❒	____________
Do you have metal implants? (including pacemaker)	❒	❒	____________
Do you wear contact lenses or glasses?	❒	❒	____________
Are you a smoker?	❒	❒	____________
Have you ever been operated on?	❒	❒	____________

List of surgeries	Year
______________________	________
______________________	________
______________________	________
______________________	________
______________________	________

Do you have any allergies (medications, respiratory, food) ❒ ❒

If yes, which ones? ____

Reactions to these allergies: ________________________________

What medication do you take and why? ____________________________

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If any of the information entered on this form changes during your treatment sessions, please notify your therapist.

Signature ____ Date ______________