CONCORDIA PHYSIO SPORT

Patient Information Form

Last Name: ______________________ First Name: __________________ Medicare #: ____________________

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

Address: ________________________________ City: ____________________ Postal Code: ____________

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

Cell: (____) ________________________ Email: ____

☐ I agree to email notifications. Initials______

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.
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 $40.00 (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? ______________

____

____

____

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

Signature ______________ Date ______________