



CLIENT REGISTRATION

Contact Information:

Name: _____ Date of Birth (mmddyy) _____
Address _____ City _____ Prov. _____
Postal Code _____ Phone (Res) _____ (Bus) _____ (Cell) _____
Fax _____ E-mail address _____ Sex: **M** **F**
If younger than 18 years of age, parents name & daytime phone #: _____

HealthCare Information:

a) Personal Healthcare # _____
b) Family Doctor (name): _____
Consent to send assessment and treatment information to your doctor: **Yes** **No**
c) Have You Had Physiotherapy In The Last Year? **Yes** **No**
When & Where & Who _____ Ongoing care: **Yes** **No**
Consent to send assessment and treatment information to your physiotherapist: **Yes** **No**
d) Have You Had Massage Therapy In The Last Year? **Yes** **No**
When & Where & Who _____ Ongoing care: **Yes** **No**
Consent to send assessment and treatment information to your massage therapist: **Yes** **No**
e) Have You Had Chiropractic Care In The Last Year? **Yes** **No**
When & Where & Who _____ Ongoing care: **Yes** **No**
Consent to send assessment and treatment information to your chiropractor: **Yes** **No**
f) Is this a sport related injury? **Yes** **No** If so which sport _____
g) Did you have surgery for the current problem? **Yes** **No**

Hospital and Date _____

h) Are You Currently On Any Medication? **Yes** **No**
Name and Dosage of Medications: _____

i) Is This Injury The Result Of A Motor Vehicle Collision? **Yes** **No**
claim# _____ **policy #** _____
Date of Collision _____

What influenced your decision to choose Marda Loop Sport Physiotherapy?

Advertisement _____ Sign _____ Website _____ Location _____ Yellow pages _____ Returning patient _____
Family Doctor (name) _____ Specialist (name) _____
Coach / Teacher (name) _____ Family / Friend (name) _____
Other (describe & list name please) _____

DO YOU HAVE ANY OF THE FOLLOWING OR ANY OTHER CONDITION WHICH YOUR PHYSIOTHERAPIST SHOULD BE AWARE? PLEASE CHECK ANY AND ALL THAT APPLY:

€ current pregnancy	€ recent surgery	€ severe dizzy spells
€ infectious disease	€ metal implant	€ asthma or emphysema
€ diabetes	€ IUD	€ difficulty breathing at rest
€ high blood pressure	€ Implants i.e. breast implant	€ a reason why you should not follow an activity program even if you wanted to
€ heart disease	€ Allergies	€ Hepatitis A, B, C or Jaundice
€ circulation disorders	€ osteoporosis	€ HIV/AIDS
€ bleeding disorders	€ cancer	
€ pacemaker	€ severe headaches	
€ epilepsy	€ Using Blood Thinners	

Emergency Contact Information:

Name: _____ Relationship to patient _____
 Phone (RES) _____ (Bus) _____ Cell _____

Consent:

We ask you to sign in the space below in acknowledgement and understanding of your liability of any costs incurred by you and/or your child at this office. (If you are under the age of 18 years, this must be signed by your parents.)

SIGNATURE _____ DATE _____

We ask you to sign in the space below in acknowledgement and understanding of your consent to initial physiotherapy assessment which may involve the physiotherapist asking you questions, observing your movement and posture, measuring 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. (If you are under the age of 18 years, this must be signed by your parents.)

SIGNATURE _____ DATE _____

We ask you to sign in the space below in acknowledgement and understanding of your consent to initial physiotherapy treatment following the physiotherapy assessment which may but are not limited to any of the following physiotherapy treatments: soft tissue work, manual therapy, spinal manipulation, electrotherapeutic modalities, thermal modalities, acupuncture, intramuscular stimulation, exercise, taping and education. Your therapist will explain to you the potential benefits, side effects and risks associated with each treatment technique prior to its usage. You are free to ask questions at any time before, during or after your treatment and subsequent reassessments. Please understand that you can stop the treatment and subsequent reassessments at any point in time. (If you are under the age of 18 years, this must be signed by your parents.)

SIGNATURE _____ DATE _____

This information is collected under then authority of the Health Information Act. The above mentioned information is collected to ensure proper medical treatment can be provided and to evaluate rehabilitation procedures, and assess injury. Any questions can be directed to Greg Redman, Privacy Officers for Marda Loop Sport Physiotherapy at 243-5004.