MARDA
LOOP
PHYSIOTHERAPY

REGISTRATION FORM

Name: ______________________________ DOB (M/D/Y)_____/______/________

Address______________________________ City___________________ Prov. ________

Postal Code_________________ Phone (H) ___________________ (Cell) ______________

E-mail address____________________________________ Sex: **M** **F**

ALBERTA HEALTH CARE #_________________________________

Family Doctor: DR_______________________________________

Consent to send assessment and treatment information to your health care provider: **Yes** **No**

How did you hear about us? Dr Referral______ Friend_________ Website__________ Google: _________

Social Media________Other________

Emergency Contact Information

Name _________________________ Relationship ______________ Phone _____________

If younger than 18 years of age, parents name & daytime phone #:_______________

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

O Pregnancy	O Drug allergies
O Metal implant	O Osteoporosis
O Infectious disease	O Cancer
O Diabetes	O Severe headaches
O High blood pressure	O Severe dizzy spells
O Heart disease	O Asthma or emphysema
O Circulation disorders	O Difficulty breathing at rest
O Epilepsy	O Any reason why you could not follow an activity program
O Pacemaker	O Other________________________
O Recent surgery	

Are You Currently On Any Medication? **Yes** **No**

Name and Dosage of Medications: ______________________________________

IS THIS INJURY THE RESULT OF A MOTOR VEHICLE COLLISION? **Yes** **No**

CLAIM# ____________________________ POLICY #________________________________

INSURANCE CO.__________________________ DATE OF COLLISION_______________________

PLEASE NOTE: WE CANNOT BILL ALBERTA HEALTH SERVICES OR WCB. IF YOU WISH US TO BILL YOUR EXTENDED INSURANCE PLEASE LET US KNOW BEFORE YOUR VISIT

APPOINTMENTS. PLEASE CONTACT THE MARDA LOOP SPORT PHYSIO RECEPTION AS EARLY AS POSSIBLE IF YOU CAN'T MAKE YOUR SCHEDULED APPOINTMENT. For your convenience an answering machine will take your calls after hours.

Please sign the space below in acknowledgement of your CONSENT to the 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 circulatory system. You are free to ask any questions during the assessment and understand that you can stop the assessment at any point. (If you are under the age of 18, your parents must sign this).

I authorize the staff or locum to provide physiotherapy care for my condition, which may include but not be limited to manual therapy, manipulations, intramuscular stimulation (IMS) and acupuncture. I consent to the use of my personal information for billing and account payment purposes and hereby release Marda Loop Sport Physiotherapy, its employees and agents, from all claims whatsoever, which may arise because of the release of information.

I am aware that if I am unable to keep my appointment, I must notify the clinic **at least 24 hours** in advance. Please note that this does not apply to emergencies or illness.

SIGNATURE ____________________________ DATE___________________________________