Welcome to Pro Sport Rehab & Fitness!

PATIENT ENTRANCE FORM

Dear Patient, please complete this questionnaire. Your answers will help us to determine if we can help you. If we do not sincerely believe that your condition will respond satisfactorily, we will not accept your case. All information will be treated as confidential. *NOTE: Entrance & Consent forms must be updated every 24 months.

DATE: _____ ***Please Circle:*** *New Client/Returning Client*

PERSONAL INFORMATION

Name: _____

*If under 18, parent's name(s) & work/cell numbers: _____

Birth Date: ____ / ____ / ____ Age: _____
Day Month Year

Address: _____

City/Town: _____ Postal Code: _____

Phone #s: HOME _____ WORK: _____ CELL: _____

Email address: _____

Occupation (optional): _____

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

HEALTH INFORMATION

*Family Doctor (Name & Clinic): _____

*Referring Doctor: Check: Physician/Surgeon ☐ or Chiro ☐: _____

1) Please state your injury/reason for consulting our clinic:

_____

2) Were you in a recent motor vehicle accident (SGI)? Check one: **YES** ☐ **NO** ☐

If yes, **date** of accident: _____ Has SGI been notified? Check one: **YES** ☐ **NO** ☐

SGI Claim #: _____ **Personal injury Rep**: _____

3) Is this a work related injury (WCB)? Check one: **YES** ☐ **NO** ☐

If yes, date of injury: _____ Has WCB been notified? Check one: **YES** ☐ **NO** ☐

WCB Claim #: _____ **Personal injury Rep**: _____

4) Do you have private or group insurance? **YES** ☐ **NO** ☐ If yes, please complete the attached Direct Billing Information Form or hand your insurance card in to reception along with your doctor referral if you have one.

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5) **WOMEN:** Are you currently pregnant? **YES☐ NO☐** If yes, how many months? _____

6) Are you taking any medications or supplements (including Tylenol, Advil, vitamins, etc)?

If yes, please list: _____

7) Are you currently involved in any leisure activities or sports? **YES☐ NO☐**

If yes, please list: _____

8) Mark on the diagram using the appropriate symbols to indicate where you feel the described sensations. *Please include <u>all</u> affected areas.*

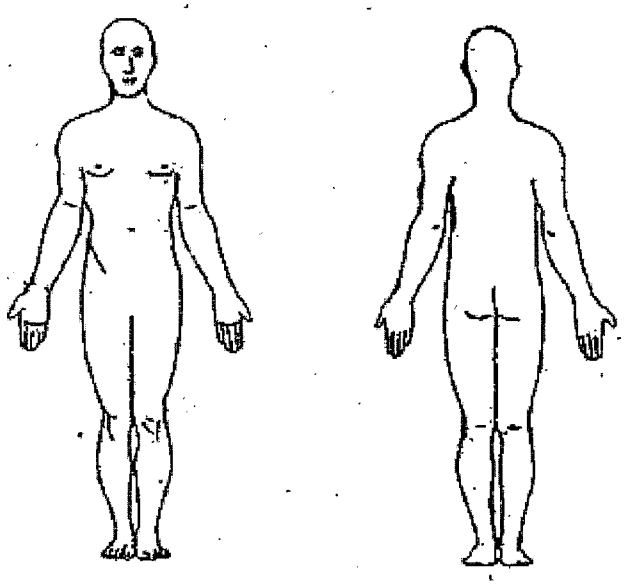
<u>CODES</u>:

Dull / Achy: **=**

Burning: **x**

Sharp: **o**

Numbness: **/**



9) Please rate pain level by making a mark on the line below:
If pain is only present in certain situations (ie: sports, running, etc.) please indicate that level as well.

No pain _____Pain as bad as it could be

1 2 3 4 5 6 7 8 9 10

10) Have you ever had any problems with any of the following? **Check/Circle all that apply to you:*

☐ High / Low blood pressure	☐ Heart trouble	☐ Arthritis/Osteoporosis
☐ Dizziness / Fainting	☐ Headaches / Migraines	☐ Stroke
☐ Neck / Back Pain	☐ Sinus trouble	☐ HIV/AIDS
☐ Contagious skin disorders	☐ Asthma	☐ Epilepsy
☐ Anxiety / Depression	☐ Digestive disorders	☐ Cancer
☐ Bowel / Bladder / Menstrual	☐ Diabetes / Thyroid	☐ Hepatitis
☐ Sleeping difficulties	☐ Fibromyalgia	☐ Severe Allergies

☐ **OTHER** (add anything not on this list): _____

☐ **NONE** ***Please check this box if none of the above applies to you***