

CONTACT INFORMATION

Name: _____ Date of Birth: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Occupation: _____ Employer: _____
Email: _____ Insurance Co: _____

MEDICAL INFORMATION

Family Doctor: _____ Chiropractor: _____
Other health professional(s): _____

Do you currently have, or had in the past any issues related to any of the following (please specify):

- | | | |
|--|--|--|
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Cancer | <input type="checkbox"/> Arthritis: |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bone / joint disease: |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Earache | <input type="checkbox"/> Fractures: |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Sprains / Strains: |
| <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Vision loss | <input type="checkbox"/> Tendonitis: |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Headaches: _____ | <input type="checkbox"/> Bursitis: |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaw (TMJ) pain |
| <input type="checkbox"/> Lymphedema | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fibromyalgia | |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Skin condition: _____ | <input type="checkbox"/> Menstrual pain |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Athlete's Foot | <input type="checkbox"/> Pregnant; due date: _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Pain with cough / sneezing? | <input type="checkbox"/> Herpes | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> HIV / AIDS | |
| <input type="checkbox"/> Smoker? | <input type="checkbox"/> Tuberculosis | |

Any allergies? _____
Any motor vehicle accidents? When? _____
Any surgeries? When? _____
Any pins, plates, wires, or pacemakers? _____
Current medications: _____

INJURY HISTORY

What is your primary complaint or major area of pain? _____
How long have you had it? _____
Can you attribute it to anything? _____
What makes it worse? _____
What makes it better? _____
Does it interfere with your work? _____ Sleep? _____ Daily routine? _____

Please sign the waiver on the back →

TREATMENT AUTHORIZATION

Medical information in my patient file is **confidential** and will not be released to any outside sources without my written permission.

I authorize the staff at Dunbar Sports Rehabilitation to use my personal information for verification of direct billing with insurance companies (if applicable).

I give the staff at Dunbar Sports Rehabilitation permission to **communicate** information about my injury with:

- My family doctor and the above named healthcare practitioners.
- Any of the following: _____

I understand that I am receiving treatment from a **Certified Athletic Therapist**, and am responsible for any treatment costs incurred.

I am responsible to ensure that my **private health insurance** covers the services provided.

Worker's Compensation Board (WCB) claims ARE NOT accepted or covered at Dunbar Sports Rehabilitation. By signing this document, I agree not to submit receipts to the WCB and self fund all treatment received.

I am aware that **cancellations** with less than 24 hours notice are subject to the full appointment fee. Please give us 24 hours notice if you are unable to keep your appointment so that we may offer your time slot to another client.

I am aware that all returned cheques are subject to a \$30 service fee.

The information provided on this form is complete to the best of my knowledge.

What is your preferred contact number? Home Cell Work

Signature: _____ Date: _____

Parental Signature if under 18: _____ Date: _____

How did you find out about Dunbar Sports Rehabilitation?
