ELITE SPORTS MEDICINE
www.EliteSportsMedicine.ca
1921 Mayor Magrath Dr. S.,#201
Lethbridge, AB T1K 2R8
Ph: (587) 425-1235
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INTAKE FORM

NAME:____ DATE OF BIRTH: _____ / _____ / _____
DD MM YYYY

HOME PH: ____________________________________ AHC: ____________________________

CELL PH: ____________________________________ REFERRED BY: ____________________________

WORK PH:____________________________________ FAMILY DOCTOR: ____________________________

EMAIL ADDRESS: ____

By submitting your email address you agree to receive email confirmation of appointments, information and/or receipts for services.

ADDRESS:____________________________________

CITY: ____________________ POSTAL CODE: ____________

OCCUPATION: ____________________________________

HOBBIES/SPORTS: ____________________________________

____

EMERGENCY CONTACT

NAME: ____________________________________

PHONE: ____________________________________

*RELATIONSHIP:*____________________________________

CHANGES, CANCELLATIONS AND MISSED APPOINTMENTS

We require a minimum of **24 hours** notice to cancel or change an appointment - **please call us at 587-425-1235**.
We will charge a **fee of $35.00** for the first appointment missed, changed or cancelled without 24 hours notice. Any additional missed, changed or cancelled appointments will be charged at full price. We understand that emergencies arise and we encourage patients to contact us should these unusual circumstances occur.

I understand this policy and agree to abide by its terms. **INITIAL:** ______________

PHYSIOTHERAPY PATIENTS

By signing this, I hereby consent to the rendering of a physical therapy evaluation and treatment as deemed appropriate by the treating therapist. I have the right to decline treatment at any time. I have stated all medical conditions that the therapist should be aware of for treatments, and I agree to inform the therapist if I experience discomfort or if new medical conditions arise. Your therapist will explain your physical therapy diagnosis and discuss treatment recommendations with you. Physical therapy, as any other type of medical care, is most effective if you participate according to the plan of treatment agreed upon with your therapist. If at any time you have questions concerning the type of services delivered or how your services are rendered, please talk with your therapist.
I have read and understand this form and agree to all consent regarding physical therapy assessment and treatment.

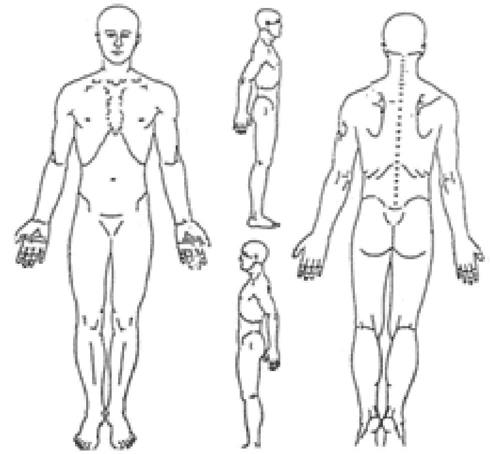
SIGNATURE: ______________________________________ **DATE:** ______________

MASSAGE THERAPY PATIENTS

By signing this, I hereby consent to the rendering of a massage therapy treatment. I have stated all medical conditions that the therapist should be aware of for treatments, and I agree to inform the therapist if I experience discomfort or if new medical conditions arise.
I have read and understand this form and agree to all consent regarding massage therapy assessment and treatment.

SIGNATURE: ______________________________________ **DATE:** ______________

Please indicate the location or injury for which you are seeking treatment:



When did your ***pain or injury start***?

____

How did it start? ________________________________

____

____

What ***aggravates*** your pain? (movements, activities, etc.)

____

What ***improves*** your pain? (ie: medicines, positions, heat, ice, etc.)

____

List ***physicians*** or ***specialists*** seen for this pain:

____

Previous ***treatments***:

- ☐ physiotherapy ☐ chiropractic ☐ acupuncture ☐ massage therapy ☐ surgery
- ☐ cortisone injections ☐ epidural injections ☐ facet injections ☐ prolotherapy injections

What ***medical tests*** have you had for this pain/injury?

- ☐ X-RAY ☐ US ☐ MRI ☐ CT ☐ BONE SCAN ☐ EMG/NCS

List all ***general medical problems/conditions*** (including pregnancy or concussion): ________________

____

List all ***surgeries***: ________________________________

____

List ***medical problems in your family***: ________________________________

____

List all ***medications*** (or attach a list): ________________________________

Medication ***allergies***: ________________________________

Please check all that apply to you and ***your lifestyle***:

- ☐ Smoking ☐ Alcohol ☐ Illegal drugs ☐ Sports/athletics ☐ Disrupted sleep
- ☐ Moodiness ☐ Urinary or bowel incontinence ☐ Night sweats ☐ Weight changes
- ☐ Fevers ☐ Rashes ☐ Muscle aches

Your personal information is collected, used, disclosed and retained in accordance with the *Health Information Act (HIA)* and *Freedom of Information and Privacy Act (FOIP)*. For any questions, comments or concerns, please contact: Trista Green, ESM Privacy Officer 587-425-1235 elitesportsmedclinic@gmail.com