Patient Registration

Sports Medicine

Patient Information

Last Name	First Name	Middle Initial	Gender: ❑ M ❑ F ❑ Other
Address	City		Date of Birth YYYY MM DD
Province / Postal Code	Home No./Cell No. / Work No.		Emergency Contact: Name, Relationship, Phone number
E-mail	Occupation		
Family Doctor	Is this a referral? ❑ Y ❑ N		

How did you hear about us?

❑ Family Physician ❑ Friend/Family ❑ Coach/Teacher ❑ Yellow Pages

❑ Signage/Location ❑ Advertising ❑ Internet ❑ Other -

Sports Played

Medical Information

Allergies (General)

Allergies to Medications

Current Medications

Previous Injuries

Current Complaint

Medical Problems

❑ Ulcers ❑ Hypertension ❑ Heart Condition ❑ Asthma

❑ Other -

Extended Health Coverage ❑ Y ❑ N

❑ Athletic Therapy ❑ Massage ❑ Orthotics ❑ Naturopathic Doctor

❑ Physiotherapy ❑ Acupuncture ❑ Bracing ❑ Osteopathy

For all appointments we require **24 hours notice** for cancellations or there will be a missed appointment charge assessed.

Patient Signature	Date

ATHLETIC THERAPY/PHYSIOTHERAPY/ACUPUNCTURE CONSENT FORM

Patient's name: _____

I consent to athletic therapy/physiotherapy assessment and/or treatment. I understand that:

- The assessment will involve physical testing for mobility, strength, endurance, and functional movements in order to determine the cause of my symptoms. A reassessment will be performed at subsequent visits in order to monitor progress.
- The therapist will need to see my area of symptoms, which may require wearing special clothing (i.e. tank top or shorts) or removing clothing (i.e. shirt or socks).
- The therapist will need to touch my area of symptoms in order to test for abnormal results or to perform certain treatments.
- The assessment or treatment may cause soreness or aggravation of my symptoms. This is usually mild and resolves within 24 hours.
- The therapist will discuss the results of the assessment with me and I have the right to ask questions at any time during the assessment or treatment.
- The therapist will explain the purpose, risks, and benefits of treatment and treatment options before performing any treatment.
- I have the right to withdraw consent and stop the assessment or treatment at any time.
- The Centre for Sport and Recreation Medicine is the Health Information Custodian (HIC) and is the owner of the patient chart.

_____	_____	_____
(Printed name*)	(Signature*)	(Date)

*Name and signature of parent of guardian for children under 18 years old