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 all affected areas.*

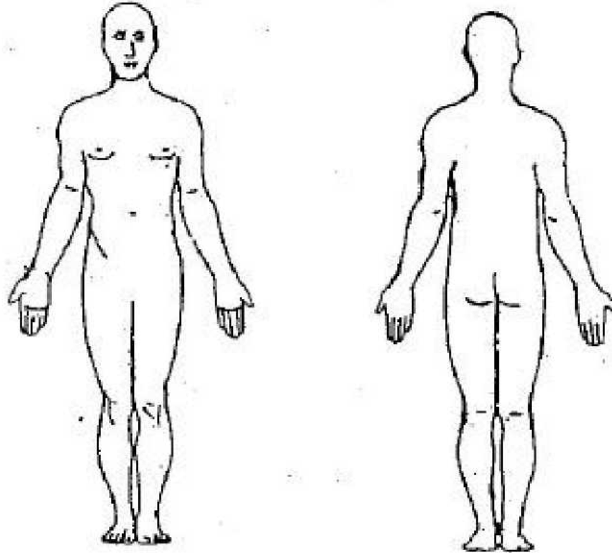
CODES:

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***

INFORMED CONSENT TO ASSESSMENT AND TREATMENT

I hereby request and consent to the performance of assessment and treatment procedures at Pro Sport Rehab & Fitness, including various modes of Physical Therapy, Athletic Therapy, Massage Therapy, Occupational Therapy, provided by the professional staff and/or those working in this clinic authorized by those staff.

I will have an opportunity to discuss with my therapist, the nature and purpose of the treatment procedures. I acknowledge that no assurance or guarantee is provided to me as to the results of the treatment. I further understand that, as in all health care there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the health professional to be able to anticipate and explain all the risks and complications. I wish to rely on the professional staff to exercise judgement during the course of the procedure(s) which they feel at the time, based upon the facts then known, is in my best interests.

I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Therapist and disclosed all medical conditions affecting me. It is my responsibility to keep the Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I consent to the release of any information that is deemed necessary to assist in the assessment and treatment of any condition that I consult Pro sport Rehab & Fitness about. This information may be released to another health care practitioner, health care facility or third party (WCB, SGI). I understand that Pro Sport Rehab & Fitness will make a reasonable attempt to contact me and explain the purpose of the release on information and that I can deny the request. If I cannot be contacted, my signature gives Pro Sport Rehab & Fitness consent for the release of my information.

I have read the above noted consent and I have had the opportunity to question the consent and my therapy. By signing this form, I agree to the above named procedures. I intend this consent form to cover the entire course of my treatment for my present condition and for any future condition(s) for which I seek treatment at this clinic.

______________________________	______________________________
PRINT Name of Patient	SIGNATURE of Patient (or parent/guardian if patient under 18)
______________________________	______________________________
Witness to Signature (administrative staff)	Date Signed

OVER →

PRO SPORT REHAB & FITNESS MISSED APPOINTMENT POLICY

For PRIVATE Paying Clients

Your appointment time is reserved for you. If you are unable to keep your allotted time, we require notification of approximately 24 hours.

We are always willing to accommodate when rescheduling; however, we will have to charge the following amounts for no-shows or inappropriate cancellations.

We use an automatic appointment reminder program which is run through our computer system. It will notify you via a text message on your phone the day before. Please be advised that you are still held personally responsible for remembering your appointment times. Note that if our computer system malfunctions for any reason, Pro Sport Rehab & Fitness staff will not be held responsible for this error, and you will be charged accordingly for your missed appointment.

☐ Please check the box if you do NOT wish to be text messaged (missed appointment policy still applies).

Receipts will not be issued for a missed appointment or inappropriate cancellation. This fee is not redeemable through insurance companies for reimbursement.

Our No Show/Missed Appointment Fee is $30.00 *Physio, Athletic, Massage & Chiropractic appointments

I have read and I understand this policy.

______________________________	______________________________
Name of Patient (print)	Signature of Patient (or parent if patient is under 18)
______________________________	______________________________
Witness to above Signature	Date

OVER →

PRO SPORT REHAB & FITNESS MISSED APPOINTMENT POLICY

For WCB and SGI Clients

Your appointment time is reserved especially for you. If you are unable to keep your allotted time, we require notification of approximately 24 hours.

Your attendance record is recorded for WCB/SGI purposes. Please be advised that Pro Sport Rehab & Fitness is required to notify WCB/SGI of any appointments where you no show or cancel.

I have read and I understand this policy.

______________________________	______________________________
Name of Patient (print)	Signature of Patient (or parent if patient is under 18)
______________________________	______________________________
Witness to above Signature	Date

OVER →

Direct Billing Information Form

Name:________________________ **Date:____________________**

DOB (YY/MM/DD):____________________

Pro Sport has offered you the convenience of direct billing to the following companies:

SK Blue Cross ___

Great West Life ___

Cowan ___

Desjardins ___

Johnson Inc. ___

Chambers of Commerce ___

Maximum Benefit or Johnston Group ___

NexgenRx ___

Industrial Alliance ___

Manulife Financial ___

Standard Life ___

Sun Life Financial ___

SSQ Financial Group ___

Green Shield ___

The Co-operators ___

Equitable Life ___

We CANNOT direct bill insurance plans for Athletic Therapy

*****Pro sport Rehab & Fitness CANNOT direct bill any other insurance companies or Secondary Insurance Policies*****

If you have selected any of the above, please provide us with the following information:

Policy#:______________________________ **ID#:__________________________________**

Policy Holder's Name:____

Relationship to Insured Member:_________________________________

Referring Doctor (First & Last Name):____

Date of Referral: ______________________

Please make sure you give your referral to reception as we need to have a copy on file for our records. Thank you!