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.

PAGE 2 (OVER)

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.*

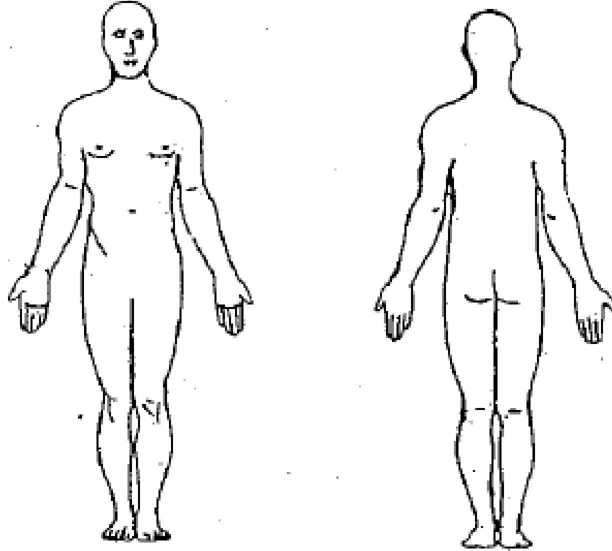
CODES:

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***

Phone:306-249-6868 Fax:306-249-6870

CONSENT TO CHIROPRACTIC TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your chiropractor and to make an informed decision about proceeding with treatment.
Chiropractic treatment includes adjustment, manipulation and mobilization of the spine and other joints of the body, soft-tissue techniques such as massage, and other forms of therapy including, but not limited to, electrical or light therapy and exercise.

Benefits

Chiropractic treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Treatment by your chiropractor can relieve pain, including headache, altered sensation, muscle stiffness and spasm. It can also increase mobility, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with chiropractic treatment vary according to each patient's condition as well as the location and type of treatment.
The risks include:

- **Temporary worsening of symptoms**- Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Skin irritation or burn**- Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar
- **Sprain or strain**- Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture**- While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention.
- **Injury or aggravation of a disc**- Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems once in a while.

  Chiropractic treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, chiropractic treatment, like many common daily activities, may aggravate the disc condition.

  The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.
- **Stroke**- Blood flows to the brain through two sets of arteries passing through the neck. These arteries may become weakened and damaged, either over a time through aging or disease, or as a result of injury. A blood clot may form in a damaged artery. All or part of the clot may break off and travel up the artery to the brain where it can interrupt blood flow and cause a stroke.

  Many common activities of daily living involving ordinary neck movements have been associated with stroke resulting from damage to an artery in the neck, or a clot that already existed in the artery breaking off and travelling up to the brain.

  Chiropractic treatment has also been associate with stroke. However, that association occurs very infrequently, and may be explained because an artery was already damaged and the patient was progressing toward a stroke

when the patient consulted the chiropractor. Present medical and scientific impairment of vision, speech, balance and brain function, as well as paralysis or death.

Alternatives

Alternatives to chiropractic treatment may include consulting with other health professionals. Your chiropractor may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns

You are encouraged to ask question at any time regarding your assessment and treatment. Bring any concerns you have to the chiropractor's attention. If you are not comfortable, you may stop treatment at any time.

Please be involved in and responsible for your care. Inform your chiropractor

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE CHIROPRACTOR

I hereby acknowledge that I have discussed with the chiropractor the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to chiropractic treatment as proposed to me.

____

Name (Please print)

________________________________ Date: _______________ 20___

Signature of patient/legal guardian

________________________________ Date: ________________ 20___

Signature of Chiropractor

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).

***NOTE: Appointment reminders are a courtesy to you and are not to be relied upon; you are still responsible for remembering your appointment.**

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

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