ELITE
SPORTS INJURY

Bring this completed form with you to your first appointment or email it to admin@physiowinnipeg.com

CLIENT INFORMATION
Physiotherapy Form

Last Name:_____ **Legal First Name:**_____ **Preferred Name:** _____

Age: _____ **Date of Birth:** _____ **Email:**_____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:**_____

Please Note: *We will be sending you email reminders for your upcoming appointments.*

Address: _____

City: _____ **Province:** _____ **Postal Code:**_____

Occupation: _____ **Employer:**_____

Emergency Contact: _____ **Phone:**_____

Family Physician: _____ **Date of Last Physical:**_____

Manitoba Health No. (9 digits) _____

WCB/MPI Claim #: _____ **Date of Injury:** _____

Insurance Provider: _____ **Insurance Contract #:** _____

Insurance Group / ID #:_____ **Policy Holder:** _____

Policy Holder D.O.B:_____ **Relation:**_____ **Phone:**_____

How were you referred to Elite?

Doctor (name & clinic/hospital):_____ **Another client/friend (name):**_____

❒ Online Search ❒ Social Media ❒ Radio ad ❒ TV ad ❒ Newspaper ad

❒ Flyer ❒ Event (specify): _____ ❒ Gym: _____ ❒ Other: _____

In order to ensure you quality service, we ask you to read the following:

1. We require AT LEAST 24 HOURS notice to change or cancel your appointment. If we don't receive sufficient notice, you will be responsible for the FULL COST of the missed visit. This notice allows us to offer your appointment to someone else and allows your therapist to adjust his/her schedule for that day.

2. We ask that you arrive at least 5 MINUTES prior to your appointment time.

3. Elite direct bills to Manitoba Blue Cross, Great-West Life, MPI and WCB. For all other coverage, we will provide you with proper documentation to submit to your insurance company.

4. Please check with your insurance company for your coverage. It is your responsibility to obtain a **medical referral**, if required by your insurance coverage. You are responsible for the FULL AMOUNT of your treatments at Elite. All invoices are payable upon receipt.

I, the undersigned, authorize Elite Performance Centres to commence treatment. I understand that injuries can arise by accident from the very nature of treatments, and hereby waive all rights to any claim or actions against Elite Performance Centres, arising from injury, loss or damage to me or to my child's property. I authorize Elite to release information pertaining to my treatment to relevant healthcare practitioners.

Note: In accordance with the Personal Health Information Act (PHIA), we endeavor to protect the privacy of our clients. Please be aware, we do not disclose patient information over the phone nor provide any information about appointments without their express consent.

I have read and understand the above terms and conditions.

Signature: _____ **Date:** _____

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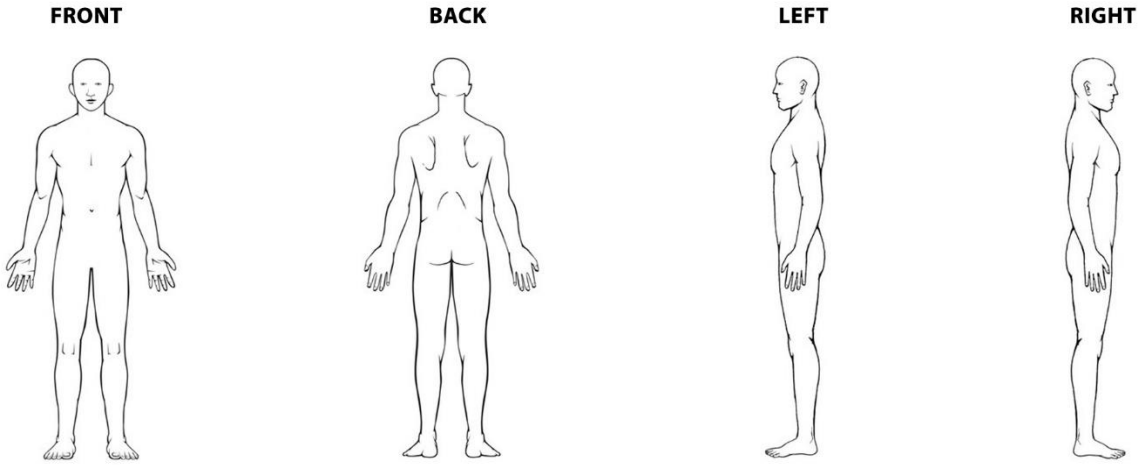
Name: _____ **Date of Injury or Surgery (if applicable):** _____

Circle the areas of pain on the diagram below:



Have you ever suffered or currently suffer from any of the following conditions?:

Cardiac problems	Yes ❒	No ❒
Pacemaker / defibrillator	Yes ❒	No ❒
Angina	Yes ❒	No ❒
High / low blood pressure	Yes ❒	No ❒
Respiratory problems	Yes ❒	No ❒
Osteoarthritis	Yes ❒	No ❒
Osteoporosis	Yes ❒	No ❒
Rheumatoid Arthritis	Yes ❒	No ❒
Bone / joint disease	Yes ❒	No ❒
Multiple Sclerosis	Yes ❒	No ❒
Muscular disorders	Yes ❒	No ❒
Diabetes	Yes ❒	No ❒
Hepatitis	Yes ❒	No ❒
Communicable disease / HIV	Yes ❒	No ❒
Blood disorder	Yes ❒	No ❒
Hyper / Hypothyroidism	Yes ❒	No ❒
Disorder of internal organs	Yes ❒	No ❒
Bowel / bladder problems	Yes ❒	No ❒
Recent weight loss	Yes ❒	No ❒
Increased painful cough / sneeze	Yes ❒	No ❒
Mental illness	Yes ❒	No ❒
Anxiety/depression	Yes ❒	No ❒
High-dose steroids	Yes ❒	No ❒
Night pain / sweats	Yes ❒	No ❒
Dizziness	Yes ❒	No ❒
Headaches	Yes ❒	No ❒

Breaks / fractures Yes ❒ No ❒
Bone (s): _____
Date (s): _____

History of cancer Yes ❒ No ❒
Types (s): _____
Date (s): _____

Surgeries Yes ❒ No ❒
Types (s): _____
Date (s): _____

Heart attack Yes ❒ No ❒
Date (s): _____

Stroke Yes ❒ No ❒
Date (s): _____

X-Ray, MRI, CT scan, DxUS Yes ❒ No ❒
Date (s): _____

Allergies Yes ❒ No ❒
List: _____

Pregnancy Yes ❒ No ❒
No. weeks: _____

Other medical conditions: _____

Medications / herbal remedies: _____