



Elite Sports Therapy

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Physio Therapy Patient Admittance Form

Name: _____
(last) (first) (initial)

Sex: Male Female Date of Birth: (mm/dd/yy) ____ / ____ / ____ Height: _____ Weight: _____ lbs

Home address: _____
(street) (city/province) (postal code)

Phone number: (____) (____) (____)
Home Work Cell

E-mail address: _____ Do you wish to receive newsletters by e-mail?
yes no

Occupation: _____

In case of emergency, who should we notify/phone: _____

Relationship to you: _____ Phone number: _____

Alberta Health Care Number: _____

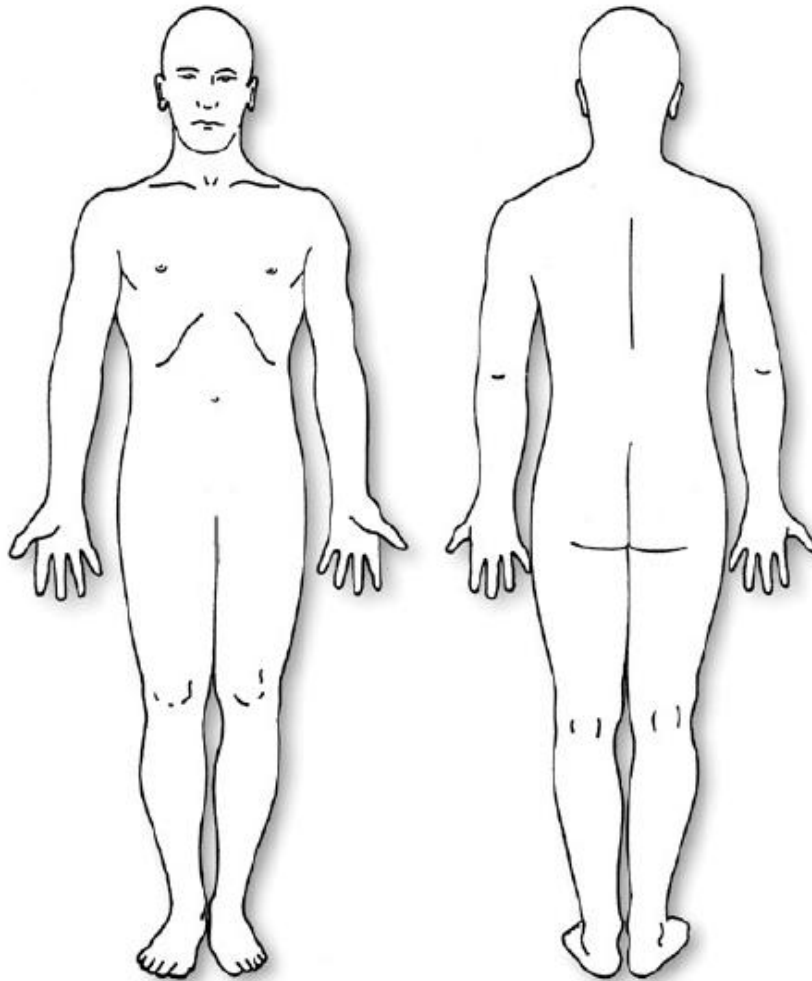
Is this a Motor Vehicle Accident case? yes no (If so, please let the receptionist know.)

Your family doctor: _____ Contact information (if any): _____

Signature: _____ Date: _____



Pain Diagram



Please indicate the areas where you are feeling pain for discomfort, according to the following scale.

Sensation:	Indicate using a:
Sharp pain	S
Numbness/Tingling	N
Achy/Dull pain	A
Burning pain	B
Decreased sensation	↓
Increased sensation	↑
Other, please specify:	?

General Systems Review

Please select any items that relate to your condition or body.

Respiratory

- Allergies
- Asthma
- Bronchitis
- Chest pain
- Cough
- Emphysema
- Frequent Colds
- Hay fever
- Pneumonia
- Smoker
- Tuberculosis

Hair

- Colour changes
- Recent loss

Ears

- Buzzing
- Discharges
- Infection
- Ringing
- Dizzy

Mouth/Throat

- Bleeding
- Hoarseness
- Difficulty swallowing
- Difficulty speaking
- Loss of taste

Vascular

- Anemia
- Discoloration
- Easy bleeding
- Easy bruising
- Hemorrhoids
- Cold hands/feet
- Leg pain after walking
- Raynaud's
- Swelling
- Thrombophlebitis
- Tranfusions
- Varicose veins

Skin

- Acne
- Boils
- Colour changes
- Dermatitis
- Eczema
- Fungal infection
- Dryness
- Goiter
- Herpetic infection
- Itching
- Lumps
- Pain
- Polyps
- Psoriasis
- Rashes
- Scars
- Shingles
- Skin Tags
- Steroid therapy
- Swelling

Musculoskeletal

- Arthritis
- Fractures
- Gout
- Hernia
- Back pain
- Neck pain
- Shoulder pain
- Elbow pain
- Wrist pain
- Hand pain
- Hip pain
- Knee pain
- Ankle pain
- Foot pain
- Muscle injury
- Stiffness
- Osteoarthritis
- Rheumatoid arthritis
- Tenderness
- Fibromyalgia
- Chronic fatigue
- Osteoporosis

Vision

- Redness
- Glaucoma
- Light Sensitivity
- Blurred vision
- Cataracts
- Double vision
- Dyslexia
- Tearing

Head

- Concussion
 - Headaches
 - Insomnia
 - Itching
 - Difficulty with memory
 - Difficulty concentrating
 - Mental illness
- Specify:

Urinary

- Bladder infection
- Kidney infection
- Blood in urine
- Bed wetting
- Burning
- Dribbling
- Hesitancy
- Incontinence
- Infection
- Kidney stone
- Nephritis
- Gall stones
- Yeast infection
- Decreased force of urine stream
- Decreased frequency of urination
- Increased frequency of urination

Sleep

- Disrupted

Cardiovascular

- Angina
- Ankle swelling
- Arrhythmias
- Arteriosclerosis
- Blood clots
- Chest pain
- Cold/blue hands, feet
- Low blood pressure
- Heart racing
- Shortness of breath
- Pounding sensation
- Heart attack
- Heart murmur
- Chronic heart failure

Gastro-intestinal

- Diarrhea
 - Constipation
 - Loss of appetite
 - Black stool
 - Bloody stool
 - Difficulty with weight gain
 - Chron's
 - Colitis
 - Foul smelling stool
 - Heart burn
 - Mucous in stool
 - Nausea
 - Pain
 - Gall bladder problem
 - Gas and bloating
 - Irritable bowel syndrome
 - Pain after eating
 - Pain during eating
 - Loss of appetite
 - Stomach cramps
 - Vomiting
 - Ulcers
 - Other digestive disorder
- Specify:

Neurological

- Alzheimer's
- Burning
- Epilepsy
- Fainting
- Numbness
- Parkinson's
- Seizures
- Tingling
- Tremors
- Multiple sclerosis
- Other:

Endocrine

- Diabetes
- Hyperthyroid
- Hypothyroid
- Increased thirst
- Water retention
- Cold intolerance
- Heat intolerance
- Increased sweating

Female Reproductive

- Pregnant
- Birth control pills
- Irregular discharge
- HIV
- Hysterectomy
- Lumps
- Menopause
- PMS
- Irregular cycle
- Sores
- Uterine fibroids
- Spotting
- Fertility problems
- Increased flow
- Painful cycle
- Pelvic inflammation
- STD
- Decreased sex drive

Male reproductive

- Impotence
- Irregular discharge
- Rashes
- Testicular pain
- Prostate problems
- STD
- Decreased sex drive

Numbness or Tingling

- Shoulders
- Arms
- Hands
- Hips
- Groin
- Legs
- Feet
- Other:

Other

- Alcoholism
- Smoker
- Cancer
- Chemotherapy
- Depression
- Hepatitis
- Night sweats
- Steroid therapy
- Surgery
- Radiation therapy
- AIDS
- HIV
- Hospitalization
Specify:
- Recent trauma
Specify:
- Recent surgery
Specify:

Family History

- Arthritis
- Genetic condition
Specify:
- Auto-immune condition
Specify:
- Cancer
- High blood pressure
- Diabetes
- High cholesterol
- Thyroid problems
- Heart disease
- Stroke
- Vascular condition
Specify:

Childhood conditions

- Measles
- Mumps
- Chicken pox
- Whooping cough
- Scarlet fever
- Diphtheria
- Rheumatic fever
- Typhoid fever
- Ear infections
- Tubes in ears
- Asthma
- Allergies
- Hospitalizations:
Specify:

Please list any current medications.



Informed Consent to Physio Therapy

CONSENT TO TREAT AND CONSENT TO COLLECT AND DISCLOSE INFORMATION

In accordance with the Federal Government's Personal Information Protection and Electronic Documents Act (PIPEDA) effective January 1, 2004, Elite Sports Therapy needs your informed consent to provide assessment and treatment services to you, and to collect and use your personal information. We want you to understand the services we provide, the cost involved and what we may do with your personal information obtained about you.

CONSENT TO TREATMENT

I agree to participate in assessments and treatments given by the treating provider. I understand that it will involve my active participation in treatment and will comply with the provider's recommendation in order to enhance my recovery. I acknowledge that my provider has given me information pertinent to my treatment, including the possible risks and side effects of the proposed treatment. Alternative courses of treatment have been explained to me. I understand the consequence of having and not having treatment. I understand that the assessment and treatment services I undergo may be administered by the treating provider, and by the support staff under the supervision of the treating provider.

I understand that Elite Sports Therapy will collect information about me for the purpose of providing an assessment and treatment services, in order to comply with the requirements of professional regulatory bodies. This information may also be conveyed to Third Party Payers, Physicians, and Legal Counsel (if applicable). This information will be stored in a secure and confidential manner.

Dated this ____ day of _____, 20_____.

Name: _____
(please print)

Witness: _____
(please print)

Patient Signature (or Legal Guardian)

Witness



Informed Consent to Acupuncture Treatment

I hereby request and consent to the performance of acupuncture and other procedures related to acupuncture, as necessary, including electroacupuncture, by my chiropractor.

I understand and am informed that in the practice of acupuncture there are some risks to treatment, including, but not limited to, minor bleeding or bruising, minor pain or soreness, nausea, fainting, infection, shock, convulsions, possible perforation of internal organs, and stuck or bent needles.

I have been advised that only pre-sterilized needles will be used. All acupuncture needles are properly disposed of after each and every treatment.

I do not expect my chiropractor to be able to anticipate and explain all possible risks and complications. I wish to rely on my chiropractor to exercise judgment during the course of the treatment which he feels at the time, based upon the facts then known, is in my best interests. I understand that the results are not guaranteed.

I have read the above consent form. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above mentioned acupuncture procedures. I intend this consent form to cover the entire course of treatment for my present and future conditions for which I seek treatment.

N.B. Female Patients:

I fully understand that in the case of pregnancy, a risk of causing fetal distress with acupuncture treatment(s) is possible. I hereby state that I am not pregnant, nor is there any possibility that I may be pregnant.

Please read before signing.

Dated this ____ day of _____, 20_____.

Name: _____
(please print)

Witness: _____
(please print)

Patient Signature (or Legal Guardian)

Witness



Fee Schedule

Chiropractic/ART

Initial visit 45-60 minutes	\$120.00	Initial visit Student/Senior	\$90.00
Subsequent visit 15 minutes	\$65.00	Subsequent visit Student/Senior	\$50.00

Treatments include Chiropractic, Active Release Techniques, Graston Technique, Kinesiotaping and/or Acupuncture, depending on the discretion of the doctor as to which is/are most appropriate.

Acupuncture

Initial visit 90 minutes	\$100.00	Subsequent visit 60 minutes	\$75.00
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Physio Therapy

Initial visit 40 minutes	\$95.00		
Subsequent visit 20 minutes	\$65.00	\$70.00 Acupuncture/IMS session	

Massage Therapy

30 minutes	\$50.00
60 minutes	\$80.00
90 minutes	\$115.00

Payment is due when services are rendered. **Twenty four (24) hours notice is required for cancellation of appointments.** If the required 24 hours notice is not provided, you may be charged for the full cost of your session.

Patients with extended health benefits must submit payment up-front, and then submit their receipts to their insurance company for reimbursement. The patient is responsible to check with their insurance company to determine if their treatment will be covered.

If this is an automobile accident case, every effort will be made to obtain payment from the insurance company, but in the event that the insurance company denies payment, the patient is responsible for the cost of any treatments to date.

If this is a WCB (Worker's Compensation Board) case, please note that *Elite Sports Therapy* is not a WCB authorized clinic. If you still wish to obtain treatment, you will be responsible for the cost of treatment, and you will be provided with a receipt. *Elite Sports Therapy* is not responsible if the fees are not reimbursed by WCB.

Signature: _____ 7 _____ Date: _____