- NEW PATIENT FORM

Please be advised all Information is Private and Confidential.

Privacy Policy in place, ask for details

Welcome, and thank you for choosing Advantage 4 Athletes Therapy Clinic. We offer quality professional, affordable health care. Direct and open communication between you and the staff is vital for proper care. We ask that you fill out the following forms to insure that you receive the appropriate care that you require. Please note all information is confidential.

CONTACT INFORMATION

Name: ____ Date: _____________________

Address: ___________________________City: __________________ Postal Code: ____________

Date of Birth: _______________ Home Phone#: ________________ Cell#: ___________________

Email Address: ____ Occupation: _________________

Emergency Contact: ______________________________ Phone #: ________________________

MEDICAL INFORMATION

Family Doctor: ___________________________________ Phone #: _______________________

Address: ___________________________City: __________________ Postal Code: ____________

Previous Treatment:

☐ Athletic Therapist ☐ Chiropractor ☐ Massage Therapist ☐ Acupuncturist ☐ Other: ________________________

Name (or Clinic Name):______________________________ Date of Last Visit:_______________

HOW DID YOU HEAR ABOUT US?

□ Walk In □ Referral:__________________________(specify)

□ Yellow pages

□ Internet: ____________________(specify) □ Advantage for Athletes Website

□ Advertisement / Event:_________________(specify) □ Other: _____________________

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MEDICAL HISTORY

What is your main complaint? (if you have been given a medical diagnosis please include it):

____

How long have you had this complaint for? ____

Previous Hospitalizations:(surgery, illness etc.)____

Other Injuries:(MVA, dislocation, sprain etc.)____

For Women – No. of Pregnancies:_______ Are you pregnant? ❑ Yes ❑No

Painful or heavy menstration? ______________ Menopause? _________

Please list any Prescription Medication you are taking: _________________________________

Please list any supplements, vitamins or herbs you are taking: _____________________________

Do you have or have you ever had:

❑ Allergies
❑ High/Low Blood Pressure
❑ Dermatitis
❑ Prolonged Bleeding
❑ Heart Disease
❑ Lung Disease
❑ Kidney Disease
❑ Liver Disease
❑ Diabetes
❑ Cancer Type: _____________
Other:_______________________

❑ Crohn's/Colitis
❑ Gall Stones
❑ Ulcer
❑ Tuberculosis
❑ Chicken Pox/Shingles
❑ Poor Circulation
❑ Phlebitis
❑ Congestive Heart Failure
❑ Stroke
❑ Seizures
❑ Thyroid Disease

❑ Psoriasis
❑ Rashes/Eczema
❑ Varicose Veins
❑ Bruise Easily
❑ Sensitive Skin
❑ Problem Acne
❑ Rheumatoid Arthritis
❑ Hepatitis
❑ AIDS

Musculoskeletal

Please check any complaints you currently have and indicate the severity:

Symptom	Mild	Moderate	Severe	**Symptom**	Mild	Moderate	Severe
Neck Pain	❑	❑	❑	Arm Pain	❑	❑	❑
Neck Stiffness	❑	❑	❑	Wrist Pain	❑	❑	❑
Headaches	❑	❑	❑	Elbow Pain	❑	❑	❑
Migraines	❑	❑	❑	Finger Pain	❑	❑	❑
Shoulder Pain	❑	❑	❑	Thigh Pain	❑	❑	❑
Pain Between Shoulders	❑	❑	❑	Hip Pain	❑	❑	❑
Tingling in Extremities	❑	❑	❑	Toe Pain	❑	❑	❑
Low Back Restriction	❑	❑	❑	Knee Pain	❑	❑	❑
Mid Back Restriction	❑	❑	❑	Ankle Pain	❑	❑	❑
Low Back Pain	❑	❑	❑	Heel Pain	❑	❑	❑
Numbness	❑	❑	❑	Osteoarthritis	❑	❑	❑

Other: ___________________________________

Systemic

Please check any complaints you currently have and indicate the severity:

Symptom	Mild	Moderate	Severe	**Symptom**	Mild	Moderate	Severe
diarrhea	❑	❑	❑	shortness of breath	❑	❑	❑
constipation	❑	❑	❑	asthma	❑	❑	❑
abdominal discomfort	❑	❑	❑	depression	❑	❑	❑
poor appetite	❑	❑	❑	fatigue	❑	❑	❑
dizziness	❑	❑	❑	chronic cough	❑	❑	❑
vision problems	❑	❑	❑	bronchitis	❑	❑	❑
hearing loss	❑	❑	❑	emphysema	❑	❑	❑

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NOTE TO CLIENT

We want your informed consent. This means that we want you to understand the services we hope to provide to you, the cost involved, and what we do with personal information we obtain about you. If you have any questions, please ask.

CONSENT FOR TREATMENT

During your assessment your Therapist will explain the treatment plan, and then have you sign the consent for treatment form.

CONSENT FOR PERSONAL INFORMATION

I understand that to provide me with Health Professional Services, Advantage 4 Athletes Therapy Clinic will collect some personal information about me (e.g., telephone number, address, gender, health history).

I am aware that Advantage 4 Athletes Therapy Clinic has a Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I have about the Privacy Policies and they have been answered to my satisfaction.

I understand and give my consent.

I authorize and direct Advantage 4 Athletes Therapy Clinic to release medical reports, x-rays and any other information as requested to my: Physician, Insurance Company, Rehabilitative Worker, WSIB, Employer, DVA, Lawyers or their representative, or other Health Care Providers upon verbal or written permission.

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.

I agree to Advantage 4 Athletes Therapy Clinic collecting, using and disclosing personal information about me as set out above and in the Advantage 4 Athletes Therapy Clinic’s Privacy Policy.

Signature: ____ Date: __________________________

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CONSENT FOR THE COST OF OUR SERVICES

Fee Schedule

Registered Massage Therapy

30 Minutes	$50
60 Minutes	$80
90 Minutes	$115

Athletic Therapy

Assessment	$90
30 Minutes	$50
45 Minutes	$65
60 Minutes	$80
90 Minutes	$115

****Please note Athletic Therapy is a different designation from Physiotherapy.***
We do not bill as Physiotherapists.

PAYMENT DIRECTION

I hereby agree that I am responsible to make payments for any services provided.
I hereby agree that I fully understand the fees for service and have read and clearly understand the above information and the implications thereof.

CONSENT TO ASSESSMENT AND TREATMENT

I hereby consent to the assessment and treatment by the athletic therapist/massage therapist including, but not limited to various electrical or thermal modalities, manual therapy, and stretching and strengthening programs.

I authorize this consent to treatment to include any athletic therapist or massage therapist employed by Advantage 4 Athletes Therapy Clinic.

I have had the opportunity to discuss with the athletic therapist/ massage therapist, the nature and purpose of treatment. I understand that the results are not guaranteed.

I further understand and am informed that, as in all health care, there are some very slight risks to treatment that is in my best interest, based on the facts then known.

I, as the client have the right to stop, clarify and ask questions about my treatment. I also have the right to discontinue treatment at any time. I understand that the information I give on this form is confidential and will be used for no other purpose than the professional therapist's records.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above mentioned athletic / massage therapy treatment. I intend this consent to cover the entire course of treatment for my present condition.

Signature: _________________________ Date: _________________________