

Edmonton
Sport
Institute

Edmonton Sport Institute
11828 - 111 Avenue
Edmonton, Alberta T5G 0E1
Tel: 780-451-1234 Fax: 780-452-9303
E-mail: admin@edmontonsportinstitute.com
www.edmontonsportinstitute.com

Clinic Registration Form

Do you currently have an appointment booked at the Edmonton Sport Institute? Yes No

If yes, Appointment Date:

Appointment Time:

Last Name:

First Name:

Date of Birth:

Age:

Gender:

Male

Female

Height: ft inches

Weight: pounds

Provincial Health Card #:

Health Care Type:

Please bring your Provincial Health Card and Photo ID with you to your initial appointment.

Address:

City:

Province:

Postal Code:

Home #: () - Work #: () - Cel #: () -

E-mail Address:

Family Physician:

Clinic Name:

Clinic E-mail Address:

Emergency Contact Person:

Emergency Contact #: () -

Did you hurt yourself at work? No Yes Date of Injury:

If yes, what is your WCB claim #?

Do you/your spouse/your parents have extended health benefits? No Yes

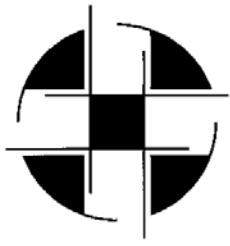
We may be able to direct bill for physiotherapy services as part of your rehabilitation. If you want us to look into direct billing for this service, please include the information below:

Group/Policy Number:

Member ID#:

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Date of injury:

Time of injury:

Injured Body Part:

Right or Left:

Describe your recent injury:

Please rate your level of pain at this time?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Extreme pain

○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

How would you describe your pain? (check all that apply)

Numbness

Pins and Needles

Burning

Sharp

Dull and Aching

Stiff and Tight

Describe any previous injuries to the same area:

Have you seen any health care worker for treatment yet?

Treatment Type

Hospital/Clinic

Date

Dr/Physio/Chiro/Trainer

Have you had any investigations (x-rays, ultrasound, MRI, etc.)?

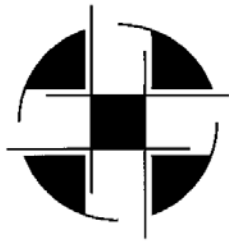
Type of Investigation

Hospital/Clinic

Date

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Have you had any previous bone or joint (orthopedic) surgery?

Body Part	Hospital/Clinic	Date	Surgeon
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Allergies: (please include drug, food, latex allergies, etc.)

Allergy	Reaction
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Have you had an adverse reaction to oral anti-inflammatory medications in the past? No Yes

If yes, describe:

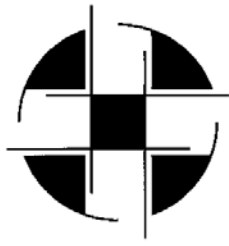
Medications: (Please include all medications that you are currently taking, including non-prescription)

Family History: (Please check all that apply to your family)

Heart Disease	Chronic back pain	Anemia	Depression
High Blood Pressure	Drug Addiction	Cancer	Alcoholism
Mental Illness	Ulcerative Colitis	Asthma	Diabetes
Severe allergies	Stomach ulcers	Psoriasis	Epilepsy
Rheumatoid arthritis	Kidney disease	Other	

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Do you have any other medical conditions? No Yes If yes, please describe:

Are you physically active?	No	Yes	Average # minutes	/ day,	days / week
Do you drink alcohol?	No	Yes	Average # drinks:	/ day,	days / week
Do you smoke cigarettes?	No	Yes	Average # cigarettes:	/ day	

Cancellation Policy

If cancelling an appointment, you are asked to please do so at least 4 hours in advance.

If you do not, or if you missed a scheduled appointment, there will be a \$35 charge.

Options for submitting this form

1. Save: Click the Save button to save this form on your computer. You may then attach the form in an e-mail and send it to admin@edmontonsportinstitute.com.
(Use this feature if your e-mail account is web-based, eg. Hotmail, Yahoo, Google, etc.)
2. Submit: Click the Submit button if you are using a computer that has your e-mail established on Outlook or Mac Mail.
3. If you are uncomfortable sending your medical information by e-mail, simply print out the form and bring it to your appointment.

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