CALGARY CENTRE FOR HEALTH™

Athletic Therapy Patient Intake Form

Name			Date
Address		City	Postal Code
Phone (Home)	(Business)	(Mobile)	
Fax	E-mail Address		
Date of Birth	Marital Status	Occupation	
Alberta Health Care #	Extended Healthcare Provider (if applicable)		

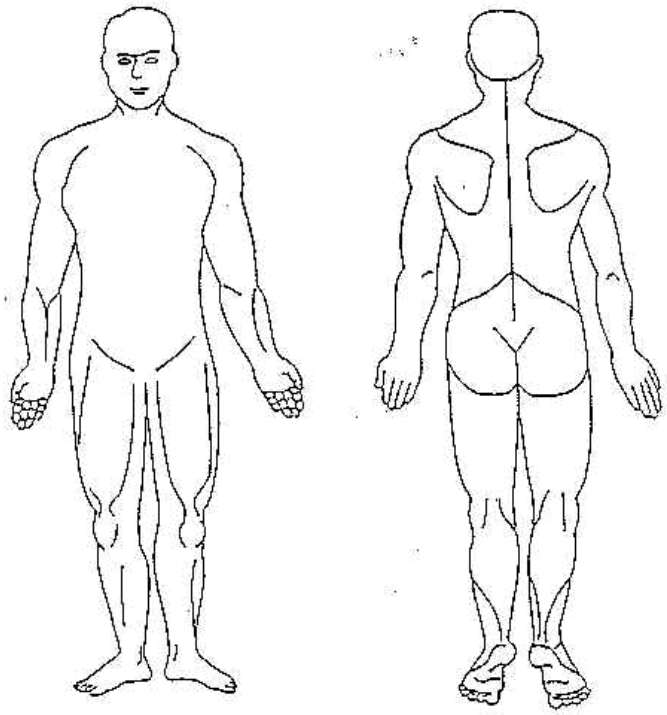
How did you hear about us?

☐ Website ☐ Street Signage ☐ Dr's Referral _____

☐ Twitter ☐ Online Search Engine ☐ Local Business _____

☐ Facebook ☐ LinkedIn ☐ Family/friend _____

☐ Other _____



****Please indicate areas of pain or discomfort on the diagram above.****

Please continue to next page

Please check all the appropriate conditions you may have.

Asthma	☐	Diabetes	☐	Cancer	☐	Migraines /Headaches	☐
Arthritis	☐	Epilepsy	☐	Prosthetics	☐	Circulatory Disorders	☐
Heart	☐	Fibromyalgia	☐	Muscle Atrophy	☐	Paralysis of _____	☐
High Blood Pressure	☐	Pregnancy	☐	Osteoporosis	☐	Chronic fatigue / pain	☐
Low Blood Pressure	☐	MS	☐	Metal Implants	☐	Other _____	☐

Do you have a family history of any of the above health conditions? _____
_____

Are you currently taking any medications? (Please list) _____
_____

Are you currently undergoing treatment from a Physician, Chiropractor, Physiotherapist, Massage Therapist, Acupuncturist or any other health practitioner? If yes, please list: _____
_____

What exercise or active living practices are you currently involved in? Please indicate for how long, how often per week and duration of activity. _____
_____

Are you currently following any specific diet or nutritional practices? _____
_____

Have you previously been diagnosed with a concussion? _____
_____

Please list your goals (walk up a flight of stairs, walk a round of golf, eg.) in order of significance. _____
_____

CALGARY CENTRE FOR HEALTH POLICIES

- Changes to your appointment must be made, at minimum, ***24 hours in advance***. This allows an opportunity for another client to fill that reserved time. Failure to comply with Calgary Centre for Health's cancellation policy may result in a missed appointment fee.
- Late arrivals will be seen for the remainder of their appointment time only. It is our goal to stay on schedule to the best of our abilities and so we must get to the next patient in time.
- Payment is due in full at the end of each treatment session. Payments will be accepted by cash, debit, or credit card, and a receipt will be provided for reimbursement by your insurance company after each visit when applicable.
  Athletic Therapy fees: **Initial visit** (new to CCH)- $100.00 **60 minutes** - $85.00 **30 minutes** - $60.00
- If your visit is as a result of a motor vehicle accident, please provide all necessary information to our staff before your appointment. This includes your private insurance information (if applicable), adjuster contact information, and claim number.

I understand, and agree with, the criteria listed under Calgary Centre for Health Policies.

_____ _____
Patient signature (parent/guardian if under 14) date

Please continue to next page

CONSENT TO ATHLETIC THERAPY EVALUATION AND TREATMENT

Athletic Therapy assessment and treatment at Calgary Centre for Health may include, but is not limited to: manual therapy techniques, electrotherapeutic modalities, thermal modalities, exercise, taping, and supportive strapping techniques. It is the policy of Calgary Centre for Health to ensure that each patient is educated about the benefits, side effects, and potential complications of each of the treatment modalities used by our therapists to decrease symptoms, and improve function, before the use of each modalities.

If you have any questions or concerns about any of your recommended treatments, you must inform your healthcare provider immediately, so they can explain the treatment rationale and/or modify your program accordingly. If at any time you choose not to participate in any type of treatment, you must inform your healthcare provider immediately. I understand and agree with the above criteria and voluntarily consent to participate in an assessment and treatment program at Calgary Centre for Health.

I understand that my consent may be withdrawn at any time during my treatment after informing my healthcare provider at Calgary Centre for Health.

I, _____, of my own free will consent to be assessed and treated.

_____ _____

Patient signature (parent/guardian if under 14) date

For office only:

I hereby certify that I have explained the nature, purpose, benefits, and risks of, and alternatives to the proposed evaluation and treatment. I have offered to answer any questions and have fully answered all such questions. I believe that the patient/guardian fully understands what I have explained and answered.

_____ _____

Certified Athletic Therapist date