



GLEN SATHER
SPORTS MEDICINE CLINIC

PHYSICAL THERAPY MEDICAL HISTORY FORM

Name: _____ Date of Birth: ____ / ____ / ____
Surname Given Name Initial Year Mon Day

PLEASE ANSWER THE FOLLOWING QUESTIONS.

1. Have you received physical therapy assessment or treatment for this body part at another Clinic within the Capital Health Region since April 1st? Y N
2. Have you had surgery for this injury within the last 8 weeks? Y N
3. Have you had a cast removed from the injured body part within the last 2 weeks? Y N
4. Is this injury the result of a workplace accident? Y N
5. Is this injury the result of a motor vehicle accident that has occurred within the last 90 days? Y N

To rule out contraindications to treatment, mark an "x" in the appropriate box if you have ever suffered any of the following health problems.

- | | | |
|--|--|--|
| <input type="checkbox"/> seizures/stroke | <input type="checkbox"/> bleeding problems | <input type="checkbox"/> depression |
| <input type="checkbox"/> osteoporosis | <input type="checkbox"/> blood clots | <input type="checkbox"/> chest pain/angina |
| <input type="checkbox"/> cancer | <input type="checkbox"/> anemia | <input type="checkbox"/> blood pressure |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> HIV | |

Indicate with an "x" which of the symptoms below you presently suffer from.

- | | | |
|--|--|--|
| <input type="checkbox"/> dizziness | <input type="checkbox"/> nausea/vomiting | <input type="checkbox"/> numb/tingling |
| <input type="checkbox"/> difficulty swallowing | <input type="checkbox"/> changes in bowel function | <input type="checkbox"/> fever/chills/sweats |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> changes in bladder function | <input type="checkbox"/> increased pain at night |

HISTORY OF PRESENT INJURY

What part of your body is presently injured? _____ When were you injured? _____

How were you injured? _____

ACKNOWLEDGEMENT

I understand my diagnosis and treatment plan will be discussed during my first appointment and that I have the right to question and/or refuse any treatment prior to it being applied. Should my injury be related to a workplace or motor vehicle accident I will accept responsibility for payment of physical therapy assessment and treatment costs should the claim be denied by the third party payer.

The ALBERTA HEALTH SERVICES (AHS) – Edmonton Area’s Community Rehabilitation Program (CRP) may provide assessment and limited treatment coverage for patients who have had recent surgery, a fracture, a severe injury according to the Determination of Need (DON) form, or patients who meet low income eligibility requirements. If you do not qualify for CRP funding, you will be charged privately for your consultation/treatment.

Conditions of Services provided by Alberta Health Services – Edmonton Area Community Rehabilitation Program (CRP)
I understand that should any portion of my assessment or treatment be funded under the CRP of the Capital Health Authority, any information collected during the assessment or treatment may be disclosed to AHS for the purpose of payment for my physical therapy and/or for review and improvement of the Community Rehabilitation Program.

If you have any questions about the collection and use of your personal/health information, please contact the Glen Sather Sport Medicine Clinic’s Privacy Officer at 492-1629. Your signature below indicates you understand and comply with the above statements.

Patient’s Signature: _____ Print Name: _____ Date: ____ / ____ / ____

If under 18 years of age, must be signed by parent/guardian