



New Patient Information

Name: _____ Email*: _____ *for Apt reminders

Parent/Guardian: _____ Alberta Health Care # _____

Phone #: _____ Date of Birth: _____

Address: _____ Sex: Male Female

City/Postal Code: _____ Motor Vehicle Accident: Yes No

Occupation: _____ Worker's Compensation Board: Yes No

Physician/Surgeon: _____ Insurance: Yes No If Yes, Insurer: _____

Emergency Contact: _____ Emergency Phone #: _____

Condition Details

Do you have a written referral for Physiotherapy? Yes ___ No___ If yes, Referred by: _____

Is this a work-related injury and have you applied for WCB benefits? Yes ___ No___

Is this an insurance claim (e.g., MVA)? Yes ___ No___

Condition Information

What condition or problem are you seeking physiotherapy for? _____

Date of Onset: _____

Is this Condition New ___ Flare-up of an ongoing condition ___

Has this condition changed recently? Yes ___ No ___ If Yes, please describe when and how it changed: _____

Medical History Related to This Condition

Have you had diagnostic imaging (e.g., X-ray, MRI, CT, ultrasound)? Yes ___ No ___ If yes, please indicate with Dates: _____

Have you had surgery for this condition? Yes ___ No ___ If yes, Date: _____

Have you been hospitalized for this condition? Yes ___ No ___ If yes, Discharge Date: _____

Have you recently had a sling, brace, or cast removed? Yes ___ No ___ If yes, Date: _____

Do you have any restrictions from your doctor or surgeon? Yes ___ No ___ If yes, please list: _____

Functional & Safety Information

Are you currently off work due to this condition? Yes ___ No ___ If yes, since what Date: _____

Have you had any falls or near-falls in the past 6 months? Yes ___ No ___ If yes, how many: _____

Have you previously received treatment for this condition? Yes ___ No ___ If yes, what type of treatment? _____

Medical Devices - Do you have a pacemaker? Yes ___ No ___