250 Bayly Street West
Ajax, Ontario L1S 3V4

TEL: 905.426.7690
FAX: 905.426.2731

total *rehab*
orthopedic & athletic medicine

# Patient Registration Form

**Last Name** | **First Name**

day | month | year

**Date of Birth**

☐ Male ☐ Female

**Sex**

**Address**

**City** | **Province** | **Postal Code**

**Home Phone** | **Business Phone**

**Cell / Other No.** | **E-mail**

☐ If you do not wish to receive e-mail from the clinic, please check here.

How did you hear about our clinic?

☐ Word of mouth ☐ Physician referral ☐ Yellow Pages ☐ Internet ☐ Other ______

**Please read carefully and sign below:**

- I understand and agree that insurance policies are an arrangement between an insurance carrier and myself. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. Payment is due when services are rendered.
- In exchange for providing necessary medical care without requiring payment at the time the service is rendered (i.e WSIB or motor vehicle accident) I agree to be responsible for all charges associated with my care, regardless of the insurance company's re-imbursement.
- Should collection procedures become necessary, I understand I am responsible for any and all legal and collection expenses, including interest.
- I understand that my medical records at Total Rehab Orthopedic and Athletic Medicine will remain private to everyone except my treating practitioner and that no records of any kind including my e-mail address will be sent to any other party without my written consent.

Patient's Signature: ______ Date: ______

Other Responsible Party: ______ Date: ______

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# Preliminary Patient History

Name: ______________________________

Occupation: ______________________ Date of Birth: day | month | year

What brings you to the clinic? ______________________________

______________________________

______________________________

______________________________

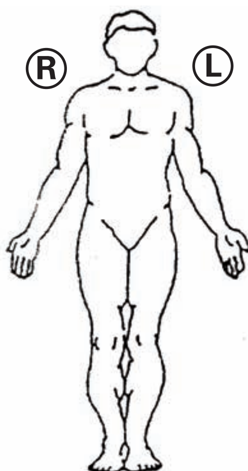
**Please mark the areas of pain on the diagrams using the keys below:**

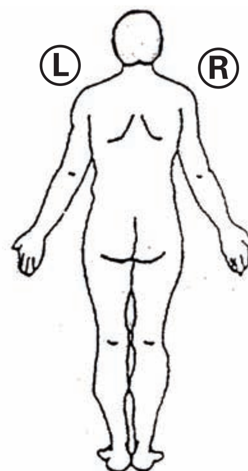
**Type of pain**

| | |
|---|---|
| SHARP | XXXX |
| DULL | OOOO |
| NUMB | #### |
| PRICKLY | /////////// |

**Intensity of pain**

| | |
|---|---|
| VERY MILD | 1 |
| MILD | 2 |
| MODERATE | 3 |
| SEVERE | 4 |
| VERY SEVERE | 5 |




Have you had X-Rays taken of the problem area?
No ❑ Yes ❑ If so;
When ______________________________
Where ______________________________

______________________________

**Medical doctor**
Name ______________________________
Phone ______________________________

**Current medications**

| Name | For what condition |
|---|---|
| | |
| | |
| | |
| | |

**Past Surgeries**
Date ______________________________
Type ______________________________

**Past Injuries**
Date ______________________________
Type ______________________________

**Life Style**
Please check the boxes that apply:

| | Never | Occasionally | Daily |
|---|---|---|---|
| Caffeine | ❑ | ❑ | ❑ |
| Insomnia | ❑ | ❑ | ❑ |
| Smoking | ❑ | ❑ | ❑ |
| Alcohol | ❑ | ❑ | ❑ |
| Exercise | ❑ | ❑ | ❑ |

Over >

## Health History

An accurate health history is important to ensure that it is safe for you to receive treatment.
If your health status changes in the future, please let your provider know immediately.
All information gathered is confidential. You will be asked to provide written authorization for release of any information.

**Please indicate conditions you are experiencing, or have experienced:**

**Musculoskeletal**
- ❑ Lower back pain
- ❑ Upper back pain
- ❑ Neck pain / stiffness
- ❑ Shoulder pain / stiffness
- ❑ Hip / Leg / Knee pain or numbness
- ❑ Foot / Ankle pain or numbness
- ❑ Arthritis
- ❑ Bursitis
- ❑ Sciatica

**Head / Neck**
- ❑ Headaches
- ❑ Migraine
- ❑ Blurred vision
- ❑ Double vision
- ❑ Earache
- ❑ Dizziness
- ❑ Ringing in Ears
- ❑ Nose bleeds
- ❑ Sinus infections

**Cardiovascular**
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Heart disease
- ❑ Poor circulation
- ❑ Palpitation
- ❑ Angina
- ❑ Swelling of ankles
- ❑ Varicose veins
- ❑ Stroke
- ❑ Abnormal heart beat
- ❑ Pacemaker

**Respiratory**
- ❑ Chronic cough
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ Asthma
- ❑ Emphysema

**Skin**
- ❑ Bruise easily
- ❑ Skin dryness
- ❑ Rashes
- ❑ Eczema

**Gastrointestinal**
- ❑ Abdominal pain
- ❑ Constipation
- ❑ Diarrhea
- ❑ Indigestion
- ❑ Gallbladder trouble
- ❑ Hemorrhoids
- ❑ Hepatitis
- ❑ Excessive gas
- ❑ Irritable Bowel

**Women only**
- ❑ Breast tenderness
- ❑ Menstrual cramps
- ❑ Irregular cycle
- ❑ PMS
- ❑ Menopausal symptoms
- ❑ Vaginal spotting
- ❑ Vaginal discharge

| | Number | Any Complications |
|---|---|---|
| Pregnancies | | |
| Miscarriages | | |
| Abortions | | |
| D&C | | |
| Other surgeries | | |

**Urinary**
- ❑ Frequent urination
- ❑ Painful urination
- ❑ Blood / Pus in urine
- ❑ Incontinence
- ❑ Urinary urgency
- ❑ Difficulty emptying bladder
- ❑ Interstitial cystitis
- ❑ Kidney problems

**Other conditions**
- ❑ Diabetes
- ❑ Cancer
- ❑ Anemia
- ❑ Convulsions
- ❑ Allergies
- ❑ Epilepsy

Therapist's Notes

Patient Signature: ______________________ Date: day / month / year