Algoma Sports Medicine & Physical Injuries Clinic

SPORTS MEDICINE
PATIENT INTAKE FORM

PAITNET INFORMATION

Name:		Date of Birth:
Health Card#	Version Code:	Gender: ❑ Male ❑ Female
Address:		Home Phone:
City:	Postal Code:	Cell Phone:
		Work Phone:

Who is your primary care provider (Physician/NP, etc.):
Insurance Provider:

As a professional courtesy, we would like to keep your primary care provider up to date regarding your injury or treatment. Is it Ok to provide them with a consultation note and updates related to your injury?: ❑ YES ❑ NO

Who may we contact in case of an emergency? _____
Relationship: _____ Phone 1: _____ Phone 2: _____

Please list below all individuals with whom we may talk to about your health concerns:
Name: _____ Relationship: _____
Name: _____ Relationship: _____

MEDICAL HISTORY

Do you have any allergies? (Medications, foods, environmental)	**Are you currently taking any medications** (prescription or over the counter, or supplements?)

Past and Present Medical History

Condition	Past	Present	Condition	Past	Present
Abdominal Pain	❑	❑	High Blood Pressure	❑	❑
Abnormal Weight	❑	❑	Irregular Menstrual Flow	❑	❑
Anemia	❑	❑	Irritable Colon	❑	❑
Anorexia	❑	❑	Jaw Pain	❑	❑
Arthritis	❑	❑	Kidney Problems	❑	❑
Bladder Infections	❑	❑	Kidney Stones	❑	❑
Blood Disorders	❑	❑	Liver/Gallbladder Problems	❑	❑
Breast Soreness / Lumps	❑	❑	Loss of Appetite	❑	❑
Cancer (Specify: _____)	❑	❑	Low Back Pain	❑	❑
Chest pain	❑	❑	Mid Back Pain	❑	❑
Chronic Cough	❑	❑	Muscular In-Coordination	❑	❑
Chronic Sinusitis	❑	❑	Neck Pain	❑	❑
Constipation / Irregular Bowels	❑	❑	Ankle / Foot Pain (LEFT / RIGHT)	❑	❑
Convulsions	❑	❑	Lower Leg / Knee Pain (LEFT / RIGHT)	❑	❑
Diabetes	❑	❑	Upper Leg / Knee Pain (LEFT / RIGHT)	❑	❑
Depression	❑	❑	Painful Urination	❑	❑
Dermatitis/Eczema/Rash	❑	❑	Rapid Heart Beat	❑	❑
Difficulty Swallowing	❑	❑	Scoliosis	❑	❑
Dizziness	❑	❑	Shoulder Pain (LEFT / RIGHT)	❑	❑
Epilepsy	❑	❑	Swelling or Stiffness of the Joints	❑	❑
Excessive Thirst	❑	❑	Thyroid Conditions	❑	❑
Fainting	❑	❑	Tinnitus (ear noises)	❑	❑
Frequent Urination	❑	❑	Ulcer	❑	❑
General Fatigue	❑	❑	Upper Arm Pain (LEFT / RIGHT)	❑	❑
Headache	❑	❑	Visual Disturbances (LEFT / RIGHT)	❑	❑
Heart Attack	❑	❑	Wrist Pain (LEFT / RIGHT)	❑	❑
Heartburn/Indigestion	❑	❑	Depression / Anxiety	❑	❑
Hepatitis	❑	❑	Other:	❑	❑

MEDICAL HISTORY CONTINUED

Family Medical History

(please specify relationship)

Condition		Condition	
Glaucoma	❑	High Cholesterol	❑
Thyroid Problems	❑	Alcoholism	❑
Hay Fever	❑	Genetic Disease	❑
Asthma	❑	Migraine	❑
Anemia	❑	Epilepsy	❑
Bleeds Easily	❑	Psoriasis	❑
Osteoporosis	❑	Arthritis	❑
Stoke	❑	Mental Illness	❑
Diabetes	❑	Eczema	❑
Heart Disease	❑	Cancer (Type)	❑
Depression	❑	Atherosclerosis	❑
High/Low Blood Pressure	❑	Other:	❑

Habits and Health Access

(please specify relationship)

Do you Smoke Cigarettes? _____/day # Years _____
Alcohol: Drinks/week: _____
Street Drugs: _____
Caffeine Drinks: _____
Sleep Pattern: ❑ satisfactory ❑ occasionally disturbed
❑ Mostly disturbed

Sexually Active: ❑ Male Partner ❑ Female Partner
Protected: ❑ All the Time, ❑ Most of the Time ❑ Never

Last Sports Physical (Date): _____
Last Routine Physical (Date): _____
Last Blood Test (Date): _____
Last Urine Test (Date): _____
Last Eye Exam (Date): _____
Last Dental Exam (Date): _____
Last Pap (Women) (Date): _____
Last Prostate/Rectal(Date): _____
Last Electrocardiogram (Date): _____

INJURY INFORMATION

Date of Injury: _____

Please describe your injury/illness: _____
_____

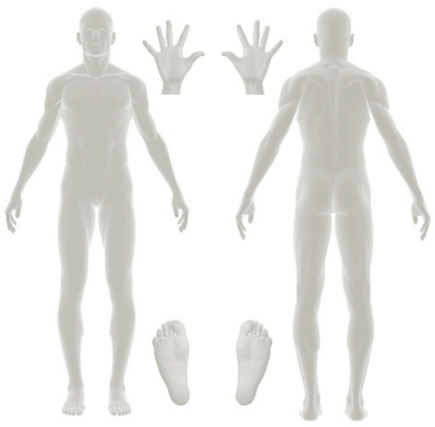
Please describe how it happened: _____
_____

Has the injury got ❑ Better or ❑ Worse since it occurred

On a Scale of 0-10, with 10 being the worst pain you have ever experienced, what would the pain on average be? _____
Currently be? _____

Would you describe the pain as: ❑ constant ❑ dull ❑ sharp ❑ throbbing ❑ tight ❑ burning ❑ tingling

Is there anything that makes it feel better? _____
Is there anything that makes it feel worse? _____
Have you received care from anyone yet for this injury? _____
Has it helped? _____



On the diagram, please mark with an "X" where the injury is, and where you are feeling the most pain. You may also mark on this diagram any pain that is radiating around by using the following:

S = Sharp/Stabbing Pain
B = Burning Pain
N = Numbness
P = Pins and Needles

CONSENT FORM

In this document "I", "my", "me" and "you" refer to the patient
"Health Care Provider" refers to any clinician employed or student employed or under the fellowship of our clinicians with Algoma Sports Medicine and Physical Injuries Clinic

Medical History and Consent to Assessment

I certify that the information contained in this patient intake form is accurate, complete and true.

I hereby request and consent to the performance of the required physical examinations and tests be completed in order to diagnose my condition. I understand that the health care provider will attempt to explain the procedures, and will attempt to provide appropriate privacy measures throughout the evaluation of my injury or illness.

Treatment Consent

Algoma Sports Medicines health care providers are trained to assess and treat many different conditions related to sports injuries. Our health care providers are trained in various manual and sports medicine techniques through various organizations in North America, and Europe as part of their medical training. This necessitates hands on techniques when diagnosing and treating various areas of the body. The treatment hypothesis and supportive research entails utilizing whole body muscle balance approach. The health care provider providing care for you will attempt to explain to you each time what they are doing, and you should advise the practitioner if there is any component of the examination or treatment that you are not comfortable with (i.e. feeling a muscle, ribs, body positioning, etc.).

The use of manual therapy is a very safe and effective treatment for many sports injuries. There is a probable 1 to 3 in a million chance of catastrophic vascular problems (stroke) with cervical manipulation. The health care provider will inform you that they would like to perform cervical manipulation, and if you wish not to have this technique performed, please advise the health care provider.

Manual therapy also carries a small probability of causing a compression fracture in the spine in predisposed individuals with spinal cancers, severe osteoporosis, bony problems, bleeding disorders, or severe degenerative diseases. All of the above can utilize very gentle manual therapy. The most common side effects are pain for a couple of days if the treatment is not aggressive, strain/sprain syndromes can also occur in 1% of cases.

Privacy Consent

This office may share my health information with other agencies/persons in accordance with current legislation and office policy. I also understand that if desired, someone can be in the room with me while being assessed and treated. Please note that the door may be open at all times during the history, physical or treatment.

By signing below I understand that my consent may be withdrawn at any time, except for actions already taken, I release the health care provider providing any assessment or treatment, the facility, directors, officers, and successors from any liabilities, claims, and causes of action, known or unknown, contingent or fixed, that may result from the treatment and/or assessment. I agree not to file a lawsuit or other action to assert a claim.

Signature: _____ Date: _____

Witness: _____ Date: _____