ZONE
SPORTS PHYSIOTHERAPY

New Client Information

Name:_____ **City:**_____

Address:_____ **Postal Code**_____

Phone number: (____)_____ -

Email: _____

Family Physician:_____

Personal Health Number:_____ **Date of Birth:** _____

Gender: (M)_____ **(F)**_____

Emergency Contact:

Name (first and last): _____ **Phone Number:** _____

Relationship to you: _____

Is your injury from a work accident? Yes ☐ No ☐

Did you report your accident to WCB? Yes ☐ No ☐

Date of Injury: **WCB Claim#:**

Is your injury from an auto accident? Yes ☐ No ☐

Did you report your injury to the SGI Injury Claims Dept? Yes ☐ No ☐

Date of Accident: **SGI Injury Claim#**

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CLIENT HISTORY AND INFORMATION

Client Name (please print)_____ Date of Birth: ___/_____/____ (dd/mm/yy)

Please **print** first and last name

Date of Assessment: ___/_____/____ (dd/mm/yy)

GENERAL HEALTH:

Please check all that apply (and details where space provided). Knowledge of these conditions may influence assessment and treatment.

- ☐ Allergies _____
- ☐ Back Problems_____
- ☐ Skin condition _____
- ☐ Bowel/Bladder Dysfunction
- ☐ Headaches
- ☐ Dizziness/Balance Disorders
- ☐ Glasses/contacts
- ☐ Hearing Problems
- ☐ Pregnancy
- ☐ Smoker
- ☐ Visual Problems
- ☐ Weight loss/gain

Have you ever been diagnosed with any of the following: (please provide details where space provided).

- ☐ Arthritis _____
- ☐ Bone Disease _____
- ☐ Blood Disorders _____
- ☐ Cancer _____
- ☐ Diabetes_____
- ☐ Heart disease_____
- ☐ Nerve Disorder_____
- ☐ Lung Disease_____
- ☐ Cataracts
- ☐ Concussion
- ☐ Depression/Anxiety
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic Bronchitis
- ☐ Cystic Fibrosis
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Epilepsy
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Multiple Sclerosis
- ☐ Osteoporosis

PREVIOUS INJURIES

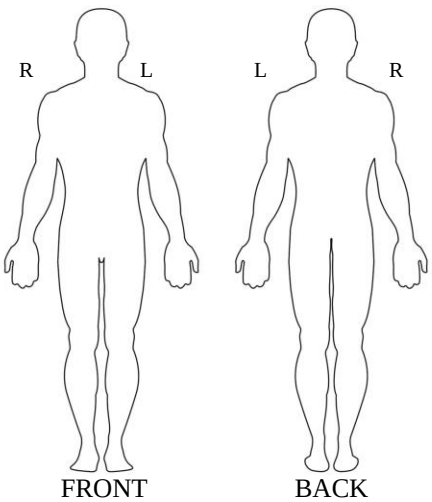
Please check all that apply and indicate type of injury (ex. fractures, dislocations, sprains, strains) OR SURGERIES (list date if possible)

- ☐ Neck_____
- ☐ TMJ/Jaw_____
- ☐ Back_____
- ☐ Pelvis_____
- ☐ Abdominal_____
- ☐ Hip_____
- ☐ Thigh_____
- ☐ Knee_____
- ☐ Calf/Achilles_____
- ☐ Ankle_____
- ☐ Foot_____
- ☐ Shoulder_____
- ☐ Elbow_____
- ☐ MVA/Auto_____
- ☐ Arm_____
- ☐ Wrist_____
- ☐ Hand_____
- ☐ Chest_____

Please complete the following about your visit ***today***

Reason for Visit: ☐Sports Injury ☐Personal Injury ☐Surgery ☐ Work Injury ☐Auto Injury ☐Other: _____

Please indicate the area(s) of injury/discomfort



PAIN SCALE RATING

Please rank your pain with "0" being no pain and "10" being worst pain possible

At Rest

0 1 2 3 4 5 6 7 8 9 10

NO PAIN — WORST POSSIBLE PAIN

With Activity

0 1 2 3 4 5 6 7 8 9 10

NO PAIN — WORST POSSIBLE PAIN

Have you had any of the following diagnostic exams/tests for this injury

- ☐ Xray
- ☐ MRI
- ☐ Bone Scan
- ☐ Ultrasound
- ☐ CT Scan
- ☐ EMG/Nerve Conduction

Have you received care from any of the following health care professionals for this injury

- ☐ Family Physician
- ☐ Orthopaedic Surgeon
- ☐ Specialist _____
- ☐ Physiotherapist
- ☐ Chiropractor
- ☐ Massage Therapist
- ☐ Acupuncture
- ☐ Other _____

Physical Activity Readiness
Questionnaire - PAR-Q
(revised 2002)

PAR-Q & YOU

(A Questionnaire for People Aged 15 to 69)

Regular physical activity is fun and healthy, and increasingly more people are starting to become more active every day. Being more active is very safe for most people. However, some people should check with their doctor before they start becoming much more physically active.

If you are planning to become much more physically active than you are now, start by answering the seven questions in the box below. If you are between the ages of 15 and 69, the PAR-Q will tell you if you should check with your doctor before you start. If you are over 69 years of age, and you are not used to being very active, check with your doctor.

Common sense is your best guide when you answer these questions. Please read the questions carefully and answer each one honestly: check YES or NO.

YES	NO		
☐	☐	1.	**Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?**
☐	☐	2.	**Do you feel pain in your chest when you do physical activity?**
☐	☐	3.	**In the past month, have you had chest pain when you were not doing physical activity?**
☐	☐	4.	**Do you lose your balance because of dizziness or do you ever lose consciousness?**
☐	☐	5.	**Do you have a bone or joint problem (for example, back, knee or hip) that could be made worse by a change in your physical activity?**
☐	☐	6.	**Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?**
☐	☐	7.	**Do you know of any other reason why you should not do physical activity?**

If you answered

YES to one or more questions

Talk with your doctor by phone or in person BEFORE you start becoming much more physically active or BEFORE you have a fitness appraisal. Tell your doctor about the PAR-Q and which questions you answered YES.

- You may be able to do any activity you want — as long as you start slowly and build up gradually. Or, you may need to restrict your activities to those which are safe for you. Talk with your doctor about the kinds of activities you wish to participate in and follow his/her advice.
- Find out which community programs are safe and helpful for you.

NO to all questions

If you answered NO honestly to all PAR-Q questions, you can be reasonably sure that you can:

- start becoming much more physically active – begin slowly and build up gradually. This is the safest and easiest way to go.
- take part in a fitness appraisal – this is an excellent way to determine your basic fitness so that you can plan the best way for you to live actively. It is also highly recommended that you have your blood pressure evaluated. If your reading is over 144/94, talk with your doctor before you start becoming much more physically active.

DELAY BECOMING MUCH MORE ACTIVE:

- if you are not feeling well because of a temporary illness such as a cold or a fever – wait until you feel better; or
- if you are or may be pregnant – talk to your doctor before you start becoming more active.

PLEASE NOTE: If your health changes so that you then answer YES to any of the above questions, tell your fitness or health professional. Ask whether you should change your physical activity plan.

Informed Use of the PAR-Q: The Canadian Society for Exercise Physiology, Health Canada, and their agents assume no liability for persons who undertake physical activity, and if in doubt after completing this questionnaire, consult your doctor prior to physical activity.

NOTE: If the PAR-Q is being given to a person before he or she participates in a physical activity program or a fitness appraisal, this section may be used for legal or administrative purposes.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

NAME _____

SIGNATURE _____ DATE _____

SIGNATURE OF PARENT _____ WITNESS _____
or GUARDIAN (for participants under the age of majority)

Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.

ZONE
SPORTS PHYSIOTHERAPY

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Consent Form

Client Name: _____ Date of Birth: ____/____/____
Please print first and last name dd mm yy

☐ Please check if the client is a minor (under the age of 18)

Consent Designate Name : (please print) _____
Relation to client: ☐ Parent ☐ Family Member ☐ Guardian

1) Assessment and Treatment:

I hereby consent to participate in my rehabilitation program at ZONE Sports Physiotherapy. This will include assessment and treatment with physiotherapy. If I have any questions or concerns regarding this treatment, I will ask the attending therapist for clarification. If I choose not to participate in the program or a portion of treatment, I will inform my physiotherapist immediately. I understand that for the duration of my treatment, my consent may be withdrawn at any time and understand that I must inform the attending physiotherapist.

_____ Date: _____
Client signature / Designate if client a minor

2) Release and Obtain Information:

I give ZONE Sports Physiotherapy my consent to release/obtain information from the following individuals with respect to my care. I understand that for the duration of my treatment, my consent may be withdrawn at any time and understand that I must inform the attending therapist.

Physician(s) Name: _____

Other (Specify): _____

_____ Date: _____
Client signature / Designate if client a minor

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