

Welcome to Optimum Sport Performance & Health Centre

Full Name: (as it appears on your Care Card)				
Former Name/Preferred Name (if applic.):				
Date of Birth (DD/MM/YYYY):				
Care Card Number:				
Street Address (Apt. # if applic.):				
City/Province:			Postal Code:	
Home Phone:			Cell Phone:	
Occupation:				
Work Phone:				
Email:				
Emergency Contact Name:			Emergency Contact Number:	
Physician's Name:			Physician's Number:	
Other Health Care Providers:			Other Health Care Providers' Numbers:	
How did you hear about our clinic?				
Please enter specific details (name of friend, doctor, etc.):				
Type of treatment you are seeking? (Check all that apply)				
Chiropractic ART	Physiotherapy Kinesiology	Massage Therapy Injury Prevention	Acupuncture Orthotics	IMS/Dry Needling Active Rehab Program
Previous treatment(s) for this condition:				

Have you, or will you be submitting a claim to:	ICBC:	Accepted	Pending	Have Legal Counsel
	WorkSafe BC:	Accepted	Pending	Have Legal Counsel
Claim Number (specific to this injury):		Adjuster's Name:		
Date of Injury/Accident:		Adjuster's Phone:		

Please describe the nature of your injury (i.e. location, symptoms, impact on activities of daily living or sport participation, etc.)

MEDICAL HISTORY

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING:

- | | | |
|--------------------------------------|----------------------------------|-----------------------------------|
| Abdominal Problems | Dislocations | Numbness or Tingling |
| Arthritis | Dizziness | Polio/Post-Polio Syndrome |
| Asthma | Fractures | Psychiatric or Psychological Care |
| Artificial Joint | Gastrointestinal Disorder | Recent Weight Loss or Gain |
| Balance Problems | High/Low Blood Pressure | Respiratory Condition |
| Blurred or Double Vision | Headaches | Seizures |
| Cancer /History of/Family History of | Heart Disease /Family History of | Shortness of Breath |
| Chest Pain | Herniated Disc | Skin Condition |
| Concussion | Hot or Cold Intolerance | Sleep Disorder |
| Currently Pregnant | Nausea/Vomiting | Stroke |
| Diabetes | Neurological Disorder | Ulcers |
| Difficulty Swallowing/Eating | Osteoporosis/Low Bone Density | Vascular Disease |
| Other: | | |

Please list all surgeries and/or significant injuries/accidents (with approximate date):

Please list all medications and/or supplements currently being taken:

Are you currently a smoker? YES NO If yes, how many cigarettes per day?: _____

Have you smoked in the past? YES NO



Please list any illnesses or conditions that run in your immediate family:

CANCELLATION POLICY

The time of your appointment has been specifically set aside for you. We require **24 hours notice** for cancellation of an appointment. You will be charged the entire visit fee for a missed appointment or short-notice cancellation. As a courtesy to you, we are willing to change appointment times to better suit your needs with adequate notice, or in the event of an emergency.

The above information is true to the best of my knowledge. I consent to the sharing of my records between practitioners of Optimum Sport Performance & Health Centre as well as with my medical doctor and outside healthcare practitioners in order to integrate and facilitate my care. I consent to receiving voice messages, as needed, about my upcoming appointments or my care at Optimum Sport Performance & Health Centre.

I consent to receiving occasional contact from Optimum by email (quarterly newsletter, important policy changes, etc.).

Patient's Signature: _____

Date: _____

Parent's Signature:
(if patient is under 18 yrs) _____

Date: _____