Patient Registration

Health Care	Number	Province	Expiry Date (if applicable)	Today's Date	
Name	***As it appears on your Health Care Card***				
	Full Name - *if* ***different*** *than name on Health Care Card*				
Date of Birth	Day	Month	Year	Age	Sex
Address	Street/Mailing				
	City/Town	Province	Postal Code		

Email	Primary Email	☐ Personal ☐ Work ☐ Other	Secondary Email	☐ Personal ☐ Work ☐ Other
Contact Number	Primary Phone Number	☐ Cell ☐ Home ☐ Work ☐ Other	Secondary Phone number	☐ Cell ☐ Home ☐ Work ☐ Other
Occupation	Job Title	Employer	Phone Number	

Family Doctor	Name	Clinic Name/Location	Phone Number
Emergency Contact	Name	Relationship	Phone Number

Is this a work-related injury?	☐ **NO,** *if no skip section.* ☐ **YES,** *if yes please answer the following questions.*
Date of Injury:	Location:
Employer at time of injury:	
Nature of injury:	
Social Insurance Number:	WCB Claim Number:

Banff Sport Medicine Uninsured Services Policy: Fees for uninsured services (not covered under provincial health care plans) will be at the discretion of the physician. This includes but is not limited to forms required by third parties and government agencies.

rev. Jan 22, 2018

Banff Sport Medicine

Initial Consult

PATIENT HISTORY

PATIENT NAME: ______________________________ Height ________ Weight ________ Date________________

Symptoms / Injury Description

What are you being seen for today? ☐ Right ☐ Left ☐Both Body part ______________________________

Did your problem come on gradually or as a result of an injury? ☐ Gradually Date of onset: ____________________
☐ Injury Date of injury: ____________________

Describe what happened: ____

____

The main problem is? ☐ Pain ☐ Instability ☐ Stiffness ☐ Weakness ☐ Other______________________

Rate your injury during the last month: (no problem) 0 1 2 3 4 5 6 7 8 9 10 (worst)

Does your injury wake you up at night? ☐ Yes ☐ No

What, if anything, makes your injury worse? ____

What, if anything, makes your injury better? ____

Sports / Recreation

List your regular sports/recreation activities:

1. ______________________ ☐ Recreational ☐ Amateur Competitive ☐ Professional Competitive ☐ Other____________________
2. ______________________ ☐ Recreational ☐ Amateur Competitive ☐ Professional Competitive ☐ Other____________________

Previous Surgery / Treatments / Tests

Have you had a similar injury or a surgery in the past?:

RIGHT: <u>**Injuries?**</u> ☐ Yes ☐ No	**LEFT:** <u>**Injuries?**</u> ☐ Yes ☐ No
Describe:	Describe:
When?	When?
RIGHT: <u>**Surgeries?**</u> ☐ Yes ☐ No	**LEFT:** <u>**Surgeries?**</u> ☐ Yes ☐ No
Describe:	Describe:
When?	When?

What treatment(s) have you had for your injury? ☐ Nothing ☐ Physiotherapy ☐ Medication ☐ Injections
☐ Sling ☐ Surgery ☐ Other: ____

What tests have you had done for your injury? ☐ X-ray ☐ MRI ☐ CT scan ☐ Ultrasound ☐ Bone Scan

MEDICAL HISTORY

Medication ____

____

Allergies ____

____

Medical Conditions

Heart ❑ ______________________________

Lungs ❑ ______________________________

Kidneys ❑ ______________________________

Diabetes ❑ ______________________________

Other ❑ ______________________________

Major Surgeries ❑ ______________________________

Anaesthetic Complications ❑ ______________________________

Bleeding Disorders ❑ ______________________________

Do you smoke? Yes ❑ No ❑ If yes, how much? ______________________

Do you drink? Yes ❑ No ❑ If yes, how much? ______________________

Please note that there is a $15.00 minimum fee for "EACH" unemployment and or private insurance form completed by the attending physician.
This must be paid before we will release the completed form

Banff Sport Medicine

Consent for Release of Information:

Instructions:

1.) In situations other than those specifically excluded in Section 40 of the Hospitals Act, this form must be signed by the patient prior to releasing and/or obtaining information about him/her.

2.) When requesting information, this form must be accompanied by a covering letter which indicates what information is requested.

I, ____

Hereby authorize the Calgary Health Region to:

1.) ☐ Obtain from (specific persons, institutions, agencies)

2.) ☐ Release to (specific persons, institutions, agencies)

Information about myself, including my medical record subject to the following exclusions:
(list here – if any)

This consent is given for a period of 6 months from the date hereof:

Date dd/Mmm/yyyy　　Signature　　Witness

Printed Name: