NOBLETON PHYSIOTHERAPY

Patient Registration Form

Welcome to Nobleton Physiotherapy. Please take a moment to complete the following registrations forms. Thank you.

Date: _____ Title (please check): ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss.

Last Name: _____ First Name: _____ Initial: _____

Age: _____ Date of Birth (y/m/d): _____ Gender: ☐ M ☐ F

Address: _____ Apt/Ste/Box#: _____

City, Province: _____ Postal Code: _____

Home Phone #: _____ Work Phone #: _____

Cell Phone #: _____ Occupation: _____

Family Doctor: _____ Family MD Phone #: _____

How did you hear about us? ☐ Family MD Referral ☐ Word of Mouth ☐ Website ☐ Google
☐ Friend/Family member ☐ Other _____

Email Address: _____

Canadian legislation (CASL) now requires we gain your consent to communicate with you through email. Below is a list of items we may communicate to you through email. Please check the appropriate box(es).

Appt. Reminders: For your convenience, NP can send email reminders for your upcoming appointments.
Would you like us to use your email for this service? ☐ Yes ☐ No Thanks

Health Professional Communication: During your treatment period your health provider may send you information regarding your injury or exercises to support your recovery.
Would you like us to use your email for this service? ☐ Yes ☐ No Thanks

Clinic Newsletter: On a semi-monthly basis we will be sending out a newsletter to update you on news/events within the clinic and educational tips for health and injury prevention.
Would you like us to use your email for this service? ☐ Yes ☐ No Thanks

Print Name: _____ Signature: _____

Date: _____

Patient Registration Form

Pain Location: (please check those that apply)

Head ☐ Jaw ☐ Neck ☐ Shoulder ☐ Elbow ☐ Wrist ☐ Hand ☐

Upper Back ☐ Mid Back ☐ Lower Back ☐ Hip ☐ Knee ☐ Ankle ☐

Lower Leg ☐ Ribs ☐ Abdomen ☐ Other ☐ (specify) _____

Date of Injury/Onset of Symptoms: _____

Cause Of Injury:

Sport ☐ (specify) _____ Work ☐ Motor Vehicle Accident ☐ Unknown ☐

Current Pain Rating (circle):

0 1 2 3 4 5 6 7 8 9 10 (Scale 0=no pain, 10=worst pain of life)

Previous Treatment for Problem: (please specify)

_____

Medical History: **Please review the following medical conditions. Some of these conditions may affect the type of treatment we perform. (Please check those that apply currently or in the past)**

Cancer ☐ Epilepsy/Seizures ☐ Respiratory Condition ☐ Osteoporosis ☐ Diabetes ☐

Heart Condition ☐ Digestion Problems ☐ Pregnancy ☐ Stroke ☐ Active Infections ☐

Blood Pressure Issues ☐ Bowel/Bladder Problems ☐ Arthritis ☐ (type) _____

Inflammatory Disease ☐ (specify) _____ Allergies ☐ (specify) _____

Past Surgery ☐ (specify) _____ Other ☐ (specify) _____

Medications: (please list)

_____

_____

Print Name: _____ **Signature:** _____

Date: _____

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