

Synergy Sports Medicine & Rehabilitation - New Patient Form

Please be advised all Information is Private and Confidential.
Privacy Policy in place, ask for details

Consent Waiver

NOTE TO CLIENT

We want your informed consent. This means that we want you to understand the services we hope to provide to you, the cost involved, and what we do with personal information we obtain about you. If you have any questions, please ask.

CONSENT FOR TREATMENT

During your assessment your Therapist will explain the treatment plan, and then have you sign the consent for treatment form.

CONSENT FOR THE COST OF OUR SERVICES

See page titled "Fee Schedule"

CONSENT FOR PERSONAL INFORMATION

I understand that to provide me with Health Professional Services, Synergy Sports Medicine & Rehabilitation will collect some personal information about me (e.g., telephone number, address, gender, health history).

I am aware that Synergy Sports Medicine & Rehabilitation has a Privacy Policy about the collection, use and disclosure of personal information, steps taken to protect the information and my right to review my personal information. I understand how the Privacy Policy applies to me. I have been given a chance to ask any questions I have about the Privacy Policies and they have been answered to my satisfaction.

I understand and give my consent

I authorize and direct Synergy Sports Medicine & Rehabilitation to release to my physician, insurance company, rehab worker, WSIB, employer (if necessary), DVA, lawyer or their representatives, or other health care providers, medical reports, x-rays and any other information as requested.

I understand that, as explained in the Policies and Procedures for Personal Information, there are some rare exceptions to these commitments.

I agree to Synergy Sports Medicine & Rehabilitation collecting, using and disclosing personal information about me as set out above and in Synergy Sports Medicine & Rehabilitation's Privacy Policy.

SIGNATURE: _____ PRINTED NAME: _____

DATE: _____ WITNESS SIGNATURE _____

NOTES by Synergy Sports Medicine & Rehabilitation

Synergy Sports Medicine & Rehabilitation - New Patient Form

Please be advised all Information is Private and Confidential.

Privacy Policy in place, ask for details

Medical History

Previous Hospitalizations:(surgery, illness etc.) _____

Other Injuries:(MVA, dislocation, sprain etc.) _____

For Women – No. of Pregnancies: _____ Are you pregnant? Yes No

Painful or heavy menstration? _____ Menopause? _____

Do you have or have you ever had:

- | | |
|---|---|
| <input type="checkbox"/> Crohn's/Colitis | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Rashes/Eczema |
| <input type="checkbox"/> Stomach/GI Ulcer | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Bruise Easily or Bleeding Disorder |
| <input type="checkbox"/> Chicken Pox/Shingles | <input type="checkbox"/> Sensitive Skin |
| <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Problem Acne |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Plantar warts of the feet/hands |
| <input type="checkbox"/> Stroke | |

Consent to Assessment and Treatment

I hereby consent to the assessment and treatment by the doctor/therapist/health professional including, but not limited to various electrical or thermal modalities, manual therapy, and stretching and strengthening programs.

I authorize this consent to treatment to include any doctor, therapist, or other health professional employed by Synergy Sports Medicine & Rehabilitation.

I have had the opportunity to discuss with the doctor, therapist, or other health professional the nature and purpose of treatment. I understand that the results are not guaranteed.

I further understand and am informed that, as in all health care, there are some very slight risks to treatment that is in my best interest, based on the facts then known.

I, as the client have the right to stop, clarify and ask questions about my treatment. I also have the right to discontinue treatment at any time. I understand that the information I give on this form is confidential and will be used for no other purpose than the health professional's records.

I have read the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to the above mentioned health professional consultation/treatment. I intend this consent to cover the entire course of treatment for my present condition.

Signature: _____

Date: _____

Synergy Sports Medicine & Rehabilitation - New Patient Form

Please be advised all Information is Private and Confidential.

Privacy Policy in place, ask for details

In order to allow us to provide you with the best possible care, please fill out this form as accurately as possible.

Please Note all information is strictly confidential. Please see our privacy policy for details.

Medical History

What is your main complaint? (if you have been given a medical diagnosis please include it):

How Long Have you had this complaint for?:

<p>Do you have or did you ever have:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Allergies <input type="checkbox"/> High/Low Blood Pressure <input type="checkbox"/> Dermatitis <input type="checkbox"/> Prolonged Bleeding <input type="checkbox"/> Heart Disease <input type="checkbox"/> Lung Disease <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer Type: _____ <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Venereal Disease <input type="checkbox"/> Seizures Other: _____ 	<p>Family Medical History:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Allergies <input type="checkbox"/> High/Low Blood Pressure <input type="checkbox"/> Dermatitis <input type="checkbox"/> Prolonged Bleeding <input type="checkbox"/> Heart Disease <input type="checkbox"/> Lung Disease <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Migraines <input type="checkbox"/> Seizures 	<p>Are you taking Prescription Medications? Please list:</p> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <p>Are you taking any:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Supplements <input type="checkbox"/> Vitamins <input type="checkbox"/> Herbs <input type="checkbox"/> Antacids <p>Please list:</p> <hr/> <hr/> <hr/>
---	---	---

Musculoskeletal

Please check any complaints you currently have and indicate the severity:

Symptom	Mild	Moderate	Severe	Symptom	Mild	Moderate	Severe
<input type="checkbox"/> Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Arm Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neck Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Elbow Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Finger Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Thigh Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pain Between Shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tingling in Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Toe Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Low Back Restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mid Back Restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ankle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Heel Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other: _____

Please See Next Page...

Synergy Sports Medicine & Rehabilitation - New Patient Form

Please be advised all Information is Private and Confidential.
Privacy Policy in place, ask for details

Systemic

Please check any complaints you currently have and indicate the severity:

- | | |
|--|--|
| <input type="checkbox"/> diarrhea <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> tinnitus <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> constipation <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> shortness of breath <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> abdominal discomfort <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> asthma <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> poor appetite <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> dizziness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> fatigue <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> difficulty concentrating <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> vision problems <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> stress <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> vision loss <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> depression <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| <input type="checkbox"/> hearing loss <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> insomnia <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |

Other: _____

Lifestyle

Please check all that apply:

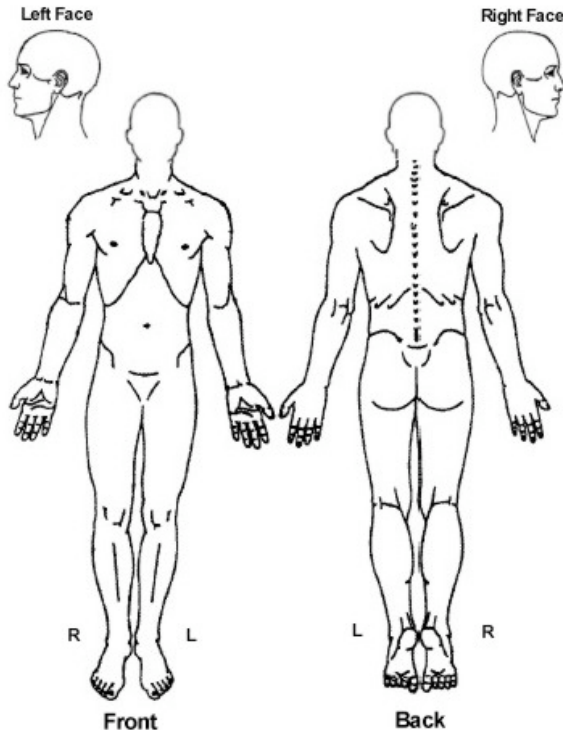
- | | |
|-----------------------------------|--|
| <input type="checkbox"/> alcohol | No. of drinks (e.g. wine, spirits, beer) per week: _____ |
| <input type="checkbox"/> caffeine | No. of drinks (e.g. coffee, tea) per day: _____ |
| <input type="checkbox"/> smoking | No. of cigarettes per day: _____ |
| <input type="checkbox"/> exercise | No. of hours per week: _____ Type of Exercise: _____ |

Symptom Diagram

In the diagrams provided below, please mark the areas on your body, which you feel best represent the pain or sensation(s) you are experiencing. Please include all areas. Use the symbols provided below.

Symbols:

- | | | |
|--------------------------|----------------------------|-----------------------|
| Numbness: _____ | Pins & Needles: :::::::::: | Burning: xxxxxxxx |
| Stabbing & Sharp: 000000 | Dull & Aching: ++++++ | Stiff & Tight: 222222 |
| _____ | 000000 | 222222 |



Please rate your level of pain along the line, with "None" being no pain at all, and "Max" being the worst pain you have ever felt.

|-----|-----|
None Max

Patient Signature: _____

Date: _____