SPPC Patient Registration			File No.
Surname First	Male Female	Family Physician Telephone Fax	

Health Card No.											Version Code	DOB DD MTH YR
Address											City	Postal Code

Tel. No. Bus. No. Cell. No. E-Mail	Extended Health Insurance provider Group No. Policy No.

Diagnosis	Diag Code	Initial Assessment Physio

Is your injury or pain the result of a motor vehicle accident? ☐ No Yes ☐ Date of Accident_____________

Insurance Co. ____ Claim No.______________________________

Name of Adjuster _____________________________________ Policy No.______________________________

Tel No. _____________________ Fax No. _____________________ Email______________________________

Please answer the following as accurately as possible. The information is treated confidentially and will be used to ensure a proper Physiotherapy Assessment.

Occupation ____

Do you have/have you had:

Heart disease?	Yes ☐	No ☐	
Heart attack?	Yes ☐	No ☐	If yes, when? _______________
Bypass surgery?	Yes ☐	No ☐	If yes, when? _______________
Angina?	Yes ☐	No ☐	
Heart arrhythmia?	Yes ☐	No ☐	
Pacemaker?	Yes ☐	No ☐	
Use nitroglycerin spray or tablets?	Yes ☐	No ☐	
High blood pressure?	Yes ☐	No ☐	
Cancer?	Yes ☐	No ☐	Type _______________ Year_______
Deep vein thrombosis or blood clot?	Yes ☐	No ☐	If yes, when? _______________
Lung disease?	Yes ☐	No ☐	
Chronic obstructive pulmonary disease?	Yes ☐	No ☐	
Emphysema?	Yes ☐	No ☐	
Asthma?	Yes ☐	No ☐	
Use an inhaler?	Yes ☐	No ☐	

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM.

File No. _ _	DOB DD MTH YR

Question	Yes	No	
Stroke?	Yes ☐	No ☐	If yes, when?______________
Parkinson's Disease?	Yes ☐	No ☐	Comment_________________
Osteoporosis?	Yes ☐	No ☐	Comment_________________
Diabetes?	Yes ☐	No ☐	
Do you take insulin?	Yes ☐	No ☐	
Fainting or dizzy spells?	Yes ☐	No ☐	
Arthritic or joint problems that restrict your activity level?	Yes ☐	No ☐	Comment_________________
Hip, knee, ankle, or back conditions that restrict your activity level?	Yes ☐	No ☐	Comment_________________
Fractures in the past year?	Yes ☐	No ☐	If yes, specify_____________
Hip/knee/other replacement?	Yes ☐	No ☐	Right side ☐ Left side ☐
Use any walking/mobility aids?	Yes ☐	No ☐	Cane☐ Walker ☐
Wear foot orthotics?	Yes ☐	No ☐	
Metal implant?	Yes ☐	No ☐	
Do you require any assistance with transferring from a sitting to a standing position?	Yes ☐	No ☐	
Visual impairment?	Yes ☐	No ☐	
Do you normally wear eye glasses?	Yes ☐	No ☐	
Hearing impairment?	Yes ☐	No ☐	
Hearing aid?	Yes ☐	No ☐	
Are you currently pregnant or think you may be?	Yes ☐	No ☐	
Have you ever or currently smoke?	Yes ☐	No ☐	

Are you currently taking any medication(s)? No ☐ Yes ☐ If yes, please list below.

Do you have any other significant conditions that have not already been indicated on this form?
(i.e. depression, anxiety, PTSD or any other mental health condition).

I understand that I will be charged for a missed appointment or for not cancelling with minimum 48 hours notice.

☐ I am signing on my behalf.
☐ I am signing as a parent, or person who is lawfully entitled to give or refuse consent, on behalf of a child under the age of 16.
☐ I am signing as the guardian of the person, or attorney for personal care of an incapable adult.

Signature of Patient/POA/Guardian *Date*