Patient Information

Name: ____
(Last) (First) (Initial)

Mailing Address: ____

City/Town: ______________________ Postal Code: ______________________

E-Mail Address: ____

Home #: ______________ Cell #: ______________ Work #: ______________

Date of Birth: M/________ D/________ Y/________ Gender: M________ F________

Occupation: ______________________ Employer: ______________________

Family Doctor: ______________________ Phone #: ______________________

Under 18? Please give name and address of Guardian

Guardian: ______________________ Relationship: ______________________

Address: ______________________ Phone: ______________________

Who can we thank for the referral? ____

Are you seeking treatment due to a motor vehicle accident? Yes ________ No ________
Are you seeking treatment due to an injury at work? Yes ________ No ________
(Please note that motor vehicle and workers compensation benefits are not available at this clinic)

Please describe the problem for which you are seeking treatment: ____

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Please provide a name and number of someone we could contact in the event of an emergency

Name: ______________________ Phone: ______________________ Relationship: ______________________

Do you have any of the following? (Check if applicable)

☐ Heart Disease ☐ High Blood Pressure ☐ Circulatory Disorder ☐ Hearing Aids
☐ Drug Allergies ☐ Diabetes ☐ Metal Implant ☐ Other
☐ Osteoporosis ☐ Cancer ☐ Recent Surgery
☐ Pace Maker ☐ Currently Pregnant ☐ Previous Fracture

Please that note that the services provided at this clinic are not covered by Alberta Health Care or the Workers Compensation Board and that there is a fee for the treatment you receive at this clinic. Payment is due at time of treatment.

By signing this form you are consent to an assessment by a qualified physiotherapist

Signature: ______________________ Date: ______________________

There will be a charge for all missed or cancelled appointments with less than 24 hours notice. By signing here I have read and understand Right Trac Physiotherapy's cancellation policy.

Signature: ______________________ Date: ______________________