UNIVERSITY OF CALGARY
Sport Medicine Centre

Personal Information

Last Name:	First Name:		Middle Initial:
Date of Birth: (mm/dd/yy)	Age:	Gender: ☐ M ☐ F ☐ O	Health Card Number:
Home Address:			
City:	Province:		Postal Code:
Email Address::	**Home Phone #:**		**Cell Phone #:**
Emergency Contact/Parent Name (if under 18)	Relationship:		Primary Phone:
Employer	Occupation		Marital Status

Referral

Please name which physician you are seeing today

Family Doctor:	Referring Physician:	Nurse Practitioner:

Were you admitted to the hospital for your injury? ☐ Yes ☐ No If yes, which hospital?

Is this injury a result of:

☐ Injury at work Date: _____
☐ Motor Vehicle Collision Date: _____
☐ Fracture or Surgery Date: _____
☐ Other Date: _____

How did you hear about our clinic?

☐ Website ☐ Events ☐ Yellow Pages ☐ Promotion ☐ Doctor Referral
☐ Social Media ☐ Poster ☐ Search Engine ☐ Family / Friend ☐ Internal Referral

History of Current Problem

Problem occurs in:

☐ neck ☐ shoulder ☐ elbow ☐ arm ☐ wrist ☐ hand ☐ head
☐ back ☐ hip ☐ knee ☐ ankle ☐ foot ☐ Other: _____

Identify problem area: ☐ right ☐ left ☐ both

Main complaint regarding problem area:

☐ pain ☐ swelling ☐ locking ☐ giving way ☐ catching ☐ Other: _____

Date of injury: _____ Activity at time of injury: _____ Is this a re-injury? ☐ Yes ☐ No

Any diagnostics? Xray CT Ultrasound MRI Other

Treatment to date? Physiotherapy Chiropractic Massage Therapy Other

Sport or activity _____

Do you compete at your main activity: ☐ Yes ☐ No ☐ If yes, at what level?

Do you presently or have you ever suffered from any of the following?

- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Lung Problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Broken Bone / Fractures
- ☐ Allergies _____
- ☐ Arthritis (eg. Rheumatoid)
- ☐ HIV / AIDS
- ☐ Kidney Problems
- ☐ Repeated Infections
- ☐ Thyroid Problems
- ☐ Skin disease or sensitivity
- ☐ Depression
- ☐ Asthma
- ☐ Epilepsy / Seizures
- ☐ Hepatitis

Have you had any surgeries?

Please provide a list of your current medications and supplements (*Please list)*

Name of preferred pharmacy?

Do you smoke? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

FOR WOMEN:

Are you currently or think you may be pregnant? ☐ Yes ☐ No

Signature: _____ **Date**: _____