CURA Physical Therapies (CPT)
Patient Intake Form

Name: _____
Last Name First Name

Alberta Health Care #:_____

Address: _____
Street City Postal code

Date of Birth: _____/_____/_____
Day / Mon / Year

Telephone: Home: _____ Work: _____ Cell: _____

Occupation: _____ Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Were you in a Motor Vehicle Accident: Yes____ No____ Date of Accident: _____

Do you have extended health benefits that cover: Physical Therapy: Yes____ No____

How did you hear about CURA Physical Therapies? _____

Consent for Assessment and Treatment:

Your participation in all aspects of your program is imperative to successful treatment. It is the policy of CURA Physical Therapies that the therapist explains treatment benefits, side effects and potential complications of assessment and treatment techniques or modalities. Physical therapy treatment may include, but is not limited to: manual techniques including spinal manipulation, electrical modalities, heat, cold, exercise and acupuncture (needles or needle-less). A number of these may be recommended during your program. Pelvic health treatment may include internal assessment and treatment. Throughout your program if you have any questions or concerns about any recommended treatment or assessment you must inform your therapist immediately so they can explain the treatment rationale and/or modify your program appropriately. If at any time you choose not to participate in the program or any portion of it, you must inform your Physical Therapist immediately. I understand and agree with the criteria above and as such agree to participate in an assessment and treatment program at CURA Physical Therapies. I understand that for the duration of my treatment, my consent may be withdrawn at any time and understand that I must inform my physiotherapist immediately.

Patient Initial_____

Consent for Release of Information:

I,_____ give CURA Physical Therapies (CPT) my consent to release information to the following individuals with respect to my care/condition:

Physician_____ Initial _____ Insurer_____ Initial _____
Laboratory_____ Initial _____ Other_____ Initial _____

Agreement for Payment:

I understand payment for services received at the clinic are my responsibility. All fees are payable to CURA Physical Therapies at time of treatment. Cash, Visa, MasterCard or Debit Card are accepted.
If my claim is submitted directly to a payor for payment (e.g., motor vehicle insurance or extended health care benefits), but the payor denies the claim and/or refuses to pay all or any of the full amount billed, I am responsible for paying the amount.
I understand the fees per visit have been explained to me. Patient Initial_____

Consent for Email Contact:

Cura Physical Therapies uses email to stay connected with you.
We use email to keep in touch about appointments, clinic updates, as well as sharing exercises and educational content that we feel may benefit you.
We may also send an occasional request for feedback.
We value our connection with you, but if at a future point you would like to unsubscribe, you can do that easily at the bottom of any email.

☐ I consent to receive email communications from Cura Physical Therapies. Patient Initial _____

Agreement to Cancellation/Missed Appointment Policy:

Cancellation Policy: I understand if I fail to provide a 24-hour advance notice of cancellation, I will be charged $40 for a late cancellation or missed appointment before receiving any further treatment. I understand that I will not be penalized for cancellations with more than 24-hour notice. Patient Initial_____

_____ Date
Patient Signature

_____ Date
Witness

CURA PHYSICAL THERAPIES

Medical History Form

Name: _____ Date of Birth: _____

Physician: _____ **Has your physician seen you for your current problem?** Yes / No

Names of Other Healthcare Providers you are seeing for your problem.

I currently have, or in the past had the following health issues Check all that apply

☐ Arthritis Osteoarthritis	☐ Rheumatoid Arthritis	☐ Osteoporosis	☐ Fibromyalgia / *Chronic fatigue*
☐ Diabetes Type____	☐ Thyroid Problems	☐ High Cholesterol	☐ Migraines/ Headaches
☐ Fainting	☐ Dizziness	☐ Falling spells	☐ Bladder Incontinence
☐ Bowel Incontinence	☐ IBS	☐Crohn's Disease	☐ Celiac Disease
☐ Chronic Constipation	☐ Recurrent Urinary infections	☐ Heart attack	☐High blood pressure
☐ Stroke	☐ Coronary Artery Disease	☐ Pacemaker	☐ Depression
☐ Anxiety	☐ Mood Disorder	☐ ADHD	☐ Epilepsy / seizure
☐ Hepatitis	☐ Asthma	☐ Allergies	☐ COPD
☐ Current Smoker	☐ Skin Condition	☐HIV/AIDS	☐ Sexual problems
☐ Substance abuse	☐ Hiatal Hernia	☐ Hearing Loss	☐ Botox Injections

☐ Neurological Condition (Specify) _____

☐ Cancer – Specify type, treatment undergone and approximate year: _____

☐ Learning Difficulties (Specify) _____

Women only

☐ Currently pregnant Yes No Birth History (number of births, types, interventions)

☐ Menstrual Problems _____ ☐ IUD _____

☐ Menopause _____ ☐ Tubal Ligation _____

Please List ALL previous surgeries and (approximate) year they occurred:_____

_____

_____

_____

_____

_____

Please list ALL previous sustained injuries (E.g. Car accident, falls, concussions, fractures, etc.) and approximate year they occurred: _____

_____

_____

_____

_____

_____

Please list all medications/ supplements and reasons for taking them: _____

_____

_____

_____

_____

What are your goals / expectation for treatment? _____

_____

_____

_____

_____

Please list any other information your feel would assist us in ensuring your safety & optimize your care_____

_____

Patient Signature **Date**

_____ _____

_____ I met with patient to discuss the medical history. They indicated that they understood the nature,
HCP INITIALS benefits potential risks, alternatives and consequences and agrees with the outcomes of this discussion.

Name_____ DOB_____

WE WOULD LIKE TO KNOW MORE ABOUT YOUR HEALTH AND WELL BEING

I go to sleep easily Yes No I sleep well Yes No I sleep a proper amount Yes No

I have significant stress in my life Yes No I have strategies for managing stress Yes No
Specify Stress Management Strategies:

_____ _____

I like to exercise regularly Yes No
Check all that apply: ☐ At Gym ☐ Exercise Classes ☐ Yoga Classes ☐ Home program ☐ Walking ☐ Running
☐ Other (Specify): _____

I am optimistic that my condition will improve. Yes No

Please name 3 activities that you are having difficulty performing (0% = unable to do 100= able to perform at level prior to onset)

	Specific Activity		Functional level 0-100%
1.	_____	→	_____
2.	_____	→	_____
3.	_____	→	_____

ABILITY INDEX QUESTIONNAIRE

It will help your care and treatment if we understand how much your condition/ problems are affecting your life. For each category please circle the number that best describes your current status. O= severe inability 10= full ability

1. **Family / Home responsibilities :** This includes chores and duties performed around the house (including yard work, and errands or favors for other family members (E.g., driving children)
   Severe inability 0 1 2 3 4 5 6 7 8 9 10 full ability

2. **Recreation:** This includes hobbies, sports and other leisure time/ fun activities
   Severe inability 0 1 2 3 4 5 6 7 8 9 10 full ability

3. **Social Activities.** This refers to activities that involve participation with friends other than family members. E.g. parties, theater, concerts, dining out and other social functions
   Severe inability 0 1 2 3 4 5 6 7 8 9 10 full ability

4. **Occupation.** Activities that relate directly to you which includes non paying jobs such home maker or volunteer worker
   Severe inability 0 1 2 3 4 5 6 7 8 9 10 full ability

5. **Self care.** This includes personal maintenance and independent every day activities such as getting dressed, taking a shower. etc
   Severe inability 0 1 2 3 4 5 6 7 8 9 10 full ability