Name _____ _____
Last Name First Name

Address _____ _____ _____ _____
Street City Postal Code

Date of Birth _____ Alberta Health Care Number _____
Day/Month/Year

Gender ☐ Female ☐ Male Gender Identity: _____ Pronouns : _____

Occupation _____ Relationship Status: _____

Primary Phone Number Cell ☐ Home ☐ I consent to receive email communications from Cura Physical Therapies. ☐ **Yes** ☐ **No**

Cell _____ Home _____

Best Contact Method ☐ **SMS/text** ☐ **Phone** ☐ **email** Email _____

Emergency Contact Person: _____ **Extended Health Care Benefits** ☐ **Yes** ☐ **No**

Relationship _____ Phone_____ Insurance Company_____

Family Physician _____ Group Number _____

Referring Physician _____ Plan ID Number _____

Were you involved in a motor vehicle accident? ☐ **Yes** ☐ **No** **Date of Accident** _____

MVA Insurance Company _____ MVA Claim Number _____

Adjuster's Name _____ Adjuster's Phone Number _____

How did you hear about CURA? _____

Consent for Assessment and Treatment:

You play an important role in your assessment and treatment at CURA Physical Therapies (CPT). You are encouraged to ask questions about your assessment or recommended treatments, so the physiotherapist can explain why they are doing the assessment or treatment. If at any time you choose not to participate in the program or any portion of it, inform your physiotherapist immediately.

It is the policy of CURA Physical Therapies that your physiotherapist explains assessment and treatment benefits, side effects, and potential complications of the techniques or modalities. Physiotherapy assessment includes talking with you, watching you move, putting our hands on you, and testing your strength. Physiotherapy treatment may include but is not limited to: manual (hands on) techniques including spinal manipulation, electrical machines, heat, cold, exercise and acupuncture (needles or needle-less). A number of these may be recommended during your program. Pelvic health conditions will need internal manual (hands on) vaginal or rectal assessment and treatment.

I understand and agree with the information above and as such agree to participate in an assessment and treatment program at CURA Physical Therapies. I understand that I can stop the assessment or treatment at any time by asking my therapist to stop, or by giving an agreed upon signal. I understand that I am responsible for immediately telling the therapist if I am having any discomfort or unusual symptoms during the assessment or treatment or do not like the technique.

Patient Signature_____ **Date** _____

FREEDOM OF INFORMATION and PROTECTION OF PRIVACY: The information you provide to CURA Physical Therapies is collected under the Freedom of information and Privacy Act in the Province of Alberta. This information is used to support your care at CPT. Your personal information is protected and can be reviewed upon request. The complete policy and procedure is available from administrative staff

Patient Name _____ **Date of Birth** _____

Consent for Release of Information:

I,_____ give CURA Physical Therapies (CPT) my consent to release information about my treatment and condition to the following individuals:

Physician_____ Initial _____ Insurer_____ Initial _____

Other _____ 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 _____

Agreement to Cancellation/Missed Appointment Policy:

Cancellation Policy: I understand I must give 24 hours notice to cancel an appointment. If I do not give 24 hours notice I will be charged a $50 fee that must be paid before receiving any further treatment. I understand that I will not be charged for cancellations that are done with 24 hours notice.

Patient Initial _____

_____ _____

Patient Signature Date

_____ _____

Witness Date

MEDICAL HISTORY FORM

cura PHYSICAL THERAPIES

Patient Name _____ **Date of Birth** _____

Many of our patients seek treatment for a specific issue or problem. In our experience, our bodies are intricately connected and can be impacted by a variety of conditions or concerns. The same is true for the treatment provided and on occasion, treatment can aggravate or affect an underlying or previous condition.
To prevent this, it is important that we get to know you better.
Please put a ☑) to conditions that apply to your current (or past) health, even if it seems insignificant.

☐ Osteoarthritis **Specify** _____		☐ Rheumatoid Arthritis	☐ Osteoporosis
☐ Fibromyalgia	☐ Chronic fatigue	☐ Thyroid Problems	
☐ Fractures **Specify** _____		☐ Diabetes Type 1	☐ Diabetes Type 2
☐ Fainting	☐ Concussion	☐ Epilepsy	☐ Seizure
☐ Bladder leakage	☐ Bladder infections	☐ IBS	☐ Crohns / Ulcerative colitis
☐ Bowel leakage	☐ Celiac Disease	☐ Bloating	☐ Chronic constipation
☐ Heart attack	☐ High blood pressure	☐ Coronary artery disease	☐ Low blood pressure
☐ High cholesterol	☐ Pacemaker	☐ Stroke	☐ Blood Clots
☐ Asthma	☐ COPD	☐ Current Smoker	☐ Hearing Loss
☐ Depression	☐ Anxiety	☐ Trauma	☐ Sleep Problems
☐ Allergies **Specify**		☐Skin condition **Specify**	_____
☐ High Stress	☐ Hepatitis C	☐ Substance Abuse	☐ HIV/ AIDS
☐ Neurological Condition **Specify**	_____	☐ Cancer **Specify**	_____

FEMALE ONLY

Pregnancy Number ___		Live Birth Number ____	
		☐ Vaginal Birth ☐ Forceps	☐ Caesarean Birth
☐ Menstrual Pain	☐ Fertility Problem	☐ Contraception Method	_____
☐ Menopause	☐ Hormone Therapy		

Current Medications or Supplements

_____

_____

Do you expect treatment to help the condition/ symptoms you need help with? ☐ **Yes** ☐ **No**

FREEDOM OF INFORMATION and PROTECTION OF PRIVACY: The information you provide to CURA Physical Therapies is collected under the Freedom of information and Privacy Act in the Province of Alberta. This information is used to support your care at CPT. Your personal information is protected and can be reviewed upon request. The complete policy and procedure is available from administrative staff

Patient Name _____ **Date of Birth** _____

LIST ALL Previous Surgeries/Motor Vehicle Injury/Injury

YEAR	Surgery/ MVA /Injuries (eg fractures)	Time to recover

What types of activities do you prefer to do? Eg Gym, home workouts, video workouts, sports

_____

What type of activities or treatments do you do for your health and well being?

_____

What 3 specific functions you would like help with and improve with treatment?

	Activity
1	
2	
3	

ABILITY INDEX QUESTIONNAIRE It helps with your care and treatment if we understand how your condition/ problems are affecting your life. For each category please circle the number that best describes your current status.

0=severe inability 10= full ability

1. **Family / Home responsibilities:** This includes tasks done around the house (including yard work, 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 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 or tasks that you do for your job or non-paying jobs such home maker
   Severe inability 0 1 2 3 4 5 6 7 8 9 10 full ability

5. **Self-care:** This includes personal tasks such as getting dressed, taking a shower. etc
   Severe inability 0 1 2 3 4 5 6 7 8 9 10 full ability

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

_____ _____

Physiotherapist signature **Date**