

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
Cell _____ Home _____ from Cura Physical Therapies. Yes No

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 Health Care Provider 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 Health Care Provider immediately.

It is the policy of CURA Physical Therapies that your Health Care Provider 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, exercise, and treatment using acupuncture needles. A number of these will be recommended during your program. **Pelvic health conditions** will need internal manual (hands on) vaginal or rectal assessment and treatment.

Acupuncture assessment involves talking with you, watching you move, putting hands on you, assessing your pulse and observing your tongue. Acupuncture treatment may include but is not limited to: inserting needles or applying pressure to stimulate specific point, cupping, manual (hands on) techniques, electrical machines and exercise.

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Patient Name : _____

Date of Birth _____

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 Health Care Provider to stop, or by giving an agreed upon signal. I understand that I am responsible for immediately telling the Health Care Provider I am having any discomfort or unusual symptoms during the assessment or treatment or do not like the technique. .

Patient Signature _____

Date _____

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

Patient Name : _____

Date of Birth _____



MEDICAL HISTORY FORM

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.

- | | | |
|--|--|--|
| <input type="checkbox"/> Osteoarthritis Specify _____ | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Fractures Specify _____ | <input type="checkbox"/> Diabetes Type 1 | <input type="checkbox"/> Diabetes Type 2 |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Concussion | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Bladder leakage | <input type="checkbox"/> Bladder infections | <input type="checkbox"/> IBS |
| <input type="checkbox"/> Bowel leakage | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Bloating |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Coronary artery disease |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD | <input type="checkbox"/> Current Smoker |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Trauma |
| <input type="checkbox"/> Allergies Specify _____ | <input type="checkbox"/> Skin condition Specify _____ | |
| <input type="checkbox"/> High Stress | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Neurological Condition Specify _____ | <input type="checkbox"/> Cancer Specify _____ | <input type="checkbox"/> HIV/ AIDS |

FEMALE ONLY

Pregnancy Number _____

Live Birth Number _____

- | | | | | |
|---|--|---|----------------------------------|--|
| <input type="checkbox"/> Menstrual Pain | <input type="checkbox"/> Fertility Problem | <input type="checkbox"/> Vaginal Birth | <input type="checkbox"/> Forceps | <input type="checkbox"/> Caesarean Birth |
| <input type="checkbox"/> Menopause | <input type="checkbox"/> Hormone Therapy | <input type="checkbox"/> Contraception Method | _____ | |

Current Medications or Supplements

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

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