NESS PHYSIOTHERAPY
AND SPORTS INJURY CLINIC

First Name: _____ Last Name: _____
Male or Female (circle one) Birth Date: _____ (MM/DD/YYYY) Age: _____
Street Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____ Ext: _____
MB Health #: _____ **(6 DIGIT)** PHIN #: _____ **(9 DIGIT)**
Email: _____
Family Physician: _____ Clinic: _____
Who has referred you to our clinic? _____
(Facebook, Instagram, YouTube, Google, Website, Yellow Pages, Sign, Family/Friend, Physician, Walk in)
Employer: _____ Occupation: _____
Emergency Contact: Name: _____ Relationship: _____ Phone: _____

MEDICAL HISTORY

*** Do you have a history of the following? Please check the appropriate response. ***

	Y	N		Y	N
Osteoarthritis	___	___	Diabetes	___	___
Rheumatoid Arthritis	___	___	Thyroid Problems	___	___
Osteoporosis	___	___	Glandular Problems	___	___
Scoliosis	___	___	Skin Conditions	___	___
Other Bone/Joint Issues	___	___	Disease of any Internal Organs	___	___
Muscular Disorder	___	___	Cancer	___	___
Stroke	___	___	Radiation /Chemotherapy	___	___
Epilepsy	___	___	Communicable Disease	___	___
Multiple Sclerosis	___	___	Dizziness	___	___
Anxiety or Depression	___	___	Fainting	___	___
Other Neurological Disorders	___	___	Anticoagulant Therapy	___	___
Heart Attack	___	___	High Dose Steroid Therapy	___	___
Pacemaker	___	___	Recent weight loss/gain	___	___
Angina	___	___	Allergies	___	___
High/Low Blood Pressure	___	___	Breathing Disorders	___	___
Other Heart Problems	___	___			

Are you currently pregnant ___YES ___NO (Please inform your therapist if you become pregnant)

*** List all previous fractures, surgeries/procedures and hospitalizations*: *

_____

_____