CALM & CONNECTION
PHYSIOTHERAPY

REGISTRATION & MEDICAL CLEARANCE FORM

Today's Date:	Service [please circle] : Physiotherapy / Mindful Core

PATIENT INFORMATION

Patient's last name:	First name:	Marital status:

Is this your legal name? ○ Yes ○ No	If not, what is your legal name?	Former name:	Birth date:	Age:	Sex: ○ M ○ F

Address:

Occupation:	Home phone no.:	Mobile phone no.:

Email:

Would you like to receive email updates and appointment reminders? [Please circle] Yes / No

General practitioner or Specialists name:	Clinic:	Contact no:

Workers compensation/CTP Insurance details:
Insurance company: Claim No: Case Manager: Date of injury/accident:

Chose clinic because/referred to clinic by (Please choose one option): ☐ Doctor's/specialist's referral ☐ Website/Facebook/Social media ☐ Family/friend ☐ Other:

IN GENERAL, HOW OFTEN DO YOU EXERCISE?

☐ 5 + times per week ☐ 3-4 x per week ☐ 1 x per week ☐ Occasionally ☐ Never

PLEASE SELECT IF ANY OF THESE HEALTH CONDITIONS AFFECT YOU. IF SO, PLEASE GIVE DETAILS BELOW.

☐ Blood Pressure
☐ Diabetes
☐ Heart Condition
☐ Neurological Condition or stroke
☐ Arthritis
☐ Asthma
☐ Respiratory Illness
☐ Osteoporosis
☐ Menopause, Age of onset:
☐ Dizziness or fainting
☐ Joint replacement
☐ Blood borne diseases, e.g. HEP C
☐ Blood clots/embolism
☐ Difficulty hearing or seeing
☐ Epilepsy or Seizures
☐ Pre or post-surgery
☐ Injury or pain, including chronic pain
☐ Pre or Post prostatectomy
☐ Pregnancy, Weeks of gestation:
☐ Incontinence
☐ Prolapse
☐ Weak pelvic floor
☐ Post-natal, Weeks:
☐ Bladder pain
☐ Pelvic pain
☐ Pre or post gynecological surgery
☐ Other

Please give details of any medical conditions selected (including dates of surgery):

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IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Home phone no:	Mobile phone no:

The above information is true to the best of my knowledge. I understand that I am responsible for notifying the physiotherapist of any changes to my health or personal information. I understand that I am financially responsible for any financial balance for therapies administered. I also authorize Calm & Connection Physiotherapy to release any information required to process my claims.

Patient/Guardian signature Date