

NAME: \_\_\_\_\_ HEALTH CARD #: \_\_\_\_\_  
 EXPIRY DATE: \_\_\_\_\_ DATE OF BIRTH (M/D/Y): \_\_\_\_/\_\_\_\_/\_\_\_\_ GENDER: M / F  
 ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_  
 PROVINCE: \_\_\_\_\_ POSTAL CODE: \_\_\_\_\_  
 PHONE: HOME \_\_\_\_\_ WORK \_\_\_\_\_ CELL \_\_\_\_\_  
 Preferred Number to be Reached: Cell / Home / Work  
 E-MAIL: \_\_\_\_\_

I agree to receive email notifications regarding the following: appointment reminders, information regarding health, wellness and injury prevention, and services offered at the clinic: YES / NO

FAMILY PHYSICIAN: \_\_\_\_\_ REFERRING PHYSICIAN: \_\_\_\_\_  
 EMERGENCY CONTACT:  
 NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

=====

1. List any prescription drugs, medications, supplements and vitamins you are taking:  
 \_\_\_\_\_  
 \_\_\_\_\_
2. List any allergies that you have (drugs, food, environmental, etc):  
 \_\_\_\_\_
3. Do you smoke? YES / NO      Have you been a smoker in the past? YES / NO
4. How many *days per week* do you engage in at least moderate intensity exercise (e.g. a brisk walk causing you to breath hard)? \_\_\_\_\_ How many *minutes* does a typical exercise session last? \_\_\_\_\_ What type of exercise activities do you engage in?  
 \_\_\_\_\_
5. For female patients: Are you pregnant? YES / POSSIBLY / NO
6. Do you have any implants in your body (eg. Joint replacement, pacemaker, plates, screws)?  
 \_\_\_\_\_
7. Is this injury due to a motor vehicle accident, a work place injury or WSIB claim? YES / NO
8. Occupation: \_\_\_\_\_ List any physical requirements that are currently problematic: \_\_\_\_\_
9. Check off if you have or had any of the following:  
 Heart trouble     Lung Condition     Hepatitis     Diabetes     Asthma  
 High Blood Pressure     Rheumatoid Arthritis     Osteoarthritis     Anxiety  
 Cancer     Liver Disease     Kidney Disease     Stomach Problems     HIV



10. List any other medical conditions that you have: \_\_\_\_\_  
\_\_\_\_\_
11. List any surgeries you have had: \_\_\_\_\_  
\_\_\_\_\_
12. List any medical conditions that run in your family (arthritis, heart disease, etc):  
\_\_\_\_\_
13. How did you hear about/find us? ( eg Website, Physician, Friend, Relative, Trirudy)  
Please specify: \_\_\_\_\_

**PHYSIOTHERAPY/MASSAGE PATIENTS CONSENT TO TREATMENT:**

I consent to a course of treatment, which may consist of manual therapy, modalities, hot/cold therapy, exercises and education. I have the right to withdraw consent to any part of the treatment at any time.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date

**PATIENTS OF DR FRANKOVICH DISCLOSURE NOTIFICATION:**

Dr Frankovich is part owner of MEDSPORT OTTAWA. You have the right to choose to consent to any treatments offered at MEDSPORT OTTAWA and to withdraw consent at any time.

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date

**CANCELLATION AND NO SHOW POLICY:** Your appointment time is reserved for you. If you need to reschedule your appointment MEDSPORT OTTAWA requires 24 hours notice. The fee charged for failure to provide 24 hours notice or failure to attend scheduled appointment is the full cost of the service that was booked. The no show or inadequate notice fee for physician appointments is \$35.00. Future appointments will be scheduled and current appointments reserved once outstanding fees are paid in full. Cancellations with less than 24 hours notice due to illness and emergencies will be exempt.

**PRIVACY POLICY:** MEDSPORT OTTAWA collects personal and health information for providing medical and rehabilitative services, in accordance with the regulations stipulated by the governing bodies of the registered health care professionals providing the service (the College of Physicians and Surgeons of Ontario, the College of Physiotherapists of Ontario, and the College

I acknowledge that I have answered all the questions accurately and that I have read and understood the cancellation and no show policy:

\_\_\_\_\_  
Signature of Patient or Parent/Guardian

\_\_\_\_\_  
Date

**MEDSPORT OTTAWA**

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