

REGINA SPORTS &

PHYSIOTHERAPY

CLINIC

1524 Albert Street
Regina, Sk. S4P 2S4
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CONTACT INFORMATION

All information will be treated as strictly confidential and will not be disclosed without your prior approval. The attached Privacy Statement will outline our policy in more detail. **PLEASE PRINT LEGIBLY.**

Name: _____
(as it appears on your Health Card)

Health Card Number _____

Mailing Address: _____
(include apartment # if applicable)

Health Card Expiry date: _____

DOB ____/____/____
 Year Month Day

City: _____

Postal Code: _____

Telephone: (H) _____ **Telephone: (W)** _____ **Telephone: (C)** _____

Email Address: _____
(used for appointment reminders/exercise programs, etc.)

Family Physician: _____

Referring Physician: _____

At what clinic did you see this physician? _____

WCB or SGI Claim Number (if relevant) _____

SGI Adjuster (if relevant) _____

Employer Name (required for WCB and SGI Claims) _____

Employer Address: _____
(required for WCB and SGI Claims)

Occupation: _____

Working? Yes No

Leisure activities/sports played: _____

Able to participate? Yes No

Have you had recent investigations for this problem? No X-rays Ultrasound CT Scan MRI
(Please circle as relevant)

Where were these taken? _____

Describe your main problem(s) in your own words.

On approximately what date did you first notice your problem?

What do you want to achieve as a result of treatment?

If problem is result of injury, please describe:

Please list any medications (including over the counter medications) that you are currently using.

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—

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Please tell us why you chose our clinic:

Past patient My doctor recommended you Yellow pages
 Word of mouth recommendation Online research Other _____

Signature

Date



CONSENT FOR PHYSIOTHERAPY EXAMINATION AND TREATMENT

This form is to certify that I consent for myself/my child under 18* to undergo physical examination, in order to help my physiotherapist determine the likely cause of the difficulties for which I/we* sought out physiotherapy services.

I also consent to participate/for my child to participate* in treatment recommended by my physiotherapist based upon his/her assessment. However, my physiotherapist shall explain to me all the risks associated with any particular treatment modality/approach, both before commencing treatment and whenever a change of treatment is undertaken. I understand that they will seek my further consent to proceed before making such changes and that by signing this consent form I do not forego my right and expectation to have any such risks associated with treatment explained to me. Nor, by signing this consent, do I give up my right to withdraw my consent for any aspect of treatment should I change my mind.

Print Name (Patient or name of Parent/Legal Guardian*) _____

Signature _____

Date _____

Print Name of Witness _____

Witness Signature _____

* Delete as appropriate



PUNCTUALITY AND APPOINTMENT CANCELLATION POLICIES

Below is an outline of the Punctuality/Appointment Cancellation Policies of the Regina Sports & Physiotherapy Clinic.

1. We request 24 hours notice of cancellation of any appointments that you are unable to attend wherever possible.
2. We reserve the right to charge a \$10.00 No Show fee for patients who do not provide adequate notice.
3. Should you miss three consecutive appointments, all further appointments will be automatically cancelled and reassigned to other patients.
4. WCB and SGI patients should be aware that we are required to report non-attendance to their respective insurers.
5. We recognize that your time is important and undertake to do everything in our power to treat you at your scheduled appointment time. In order to do that for all patients, however, this means that we may not be able to see you, or allow the full appointment time, if you arrive late for your appointment.

I acknowledge that I have read and understand the Punctuality and Cancellation Policy of the Regina Sports & Physiotherapy Clinic.

Signature

Name

Date: _____



Information Privacy Policy

Consistent with the requirements of our profession and those of The Health Information Protection Act of Saskatchewan and the Personal Information Protection and Electronic Documents Act of Canada, we acknowledge our duty and responsibility to hold in confidence your personal information gathered in the course of our professional relationship.

To ensure our accountability, we have developed this policy and trained our Staff about the policy and its implementation.

We collect and share your personal information with and from your other health care providers, insurance carriers, your employer and government agencies, where required by law to:

Provide you with Physiotherapy Services.

Obtain payment of your account.

To provide information and follow up respecting your physiotherapy services.

For quality control purposes.

We do not disclose your personal information to any third party to enable them to market their products.

Your Health Chart and information will be retained in a secure manner.

I, _____ acknowledge reviewing the privacy policy of
print name

the Regina Sports & Physiotherapy Clinic and I understand my rights of privacy with respect to my personal information.

Date: _____

Signature: _____

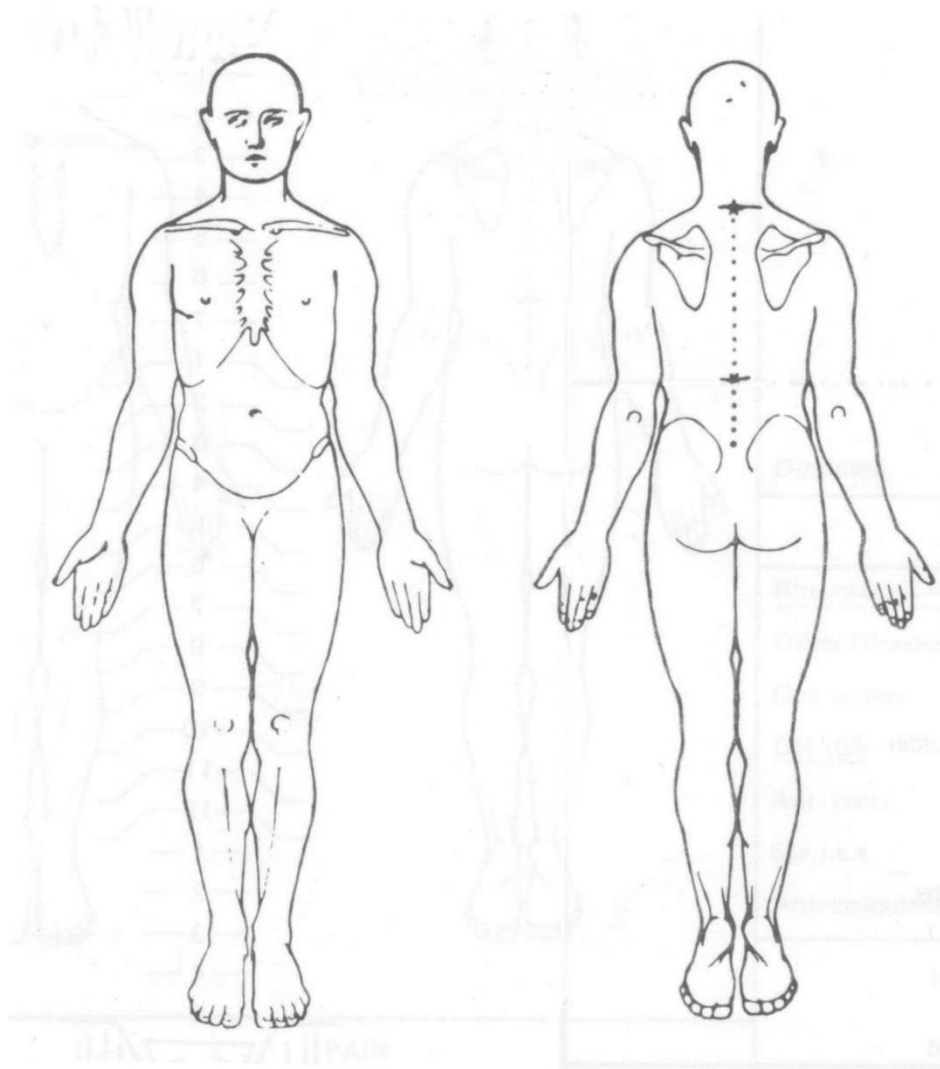
NAME _____ DATE: _____

INSTRUCTIONS

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

KEY

/// Stabbing	XXX Burning	000 Pins and Needles	=== Numbness
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Tampa Scale-11 (TSK-11)

Name:

Date:

This is a list of phrases which other patients have used to express how they view their condition. Please circle the number that best describes how you feel about each statement.

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree
1. I'm afraid I might injure myself if I exercise.	1	2	3	4
2. If I were to try to overcome it, my pain would increase.	1	2	3	4
3. My body is telling me I have something dangerously wrong-	1	2	3	4
4. People aren't taking my medical condition serious enough.	1	2	3	4
5. My accident/problem has put my body at risk for the rest of my life-	1	2	3	4
6. Pain always means I have injured my body.	1	2	3	4
7. Simply being careful that I do not make any unnecessary movements is the safest thing I can do to prevent my pain from worsening.	1	2	3	4
8. I wouldn't have this much pain if there wasn't something potentially dangerous going on in my body.	1	2	3	4
9. Pain lets me know when to stop exercising so that I don't injure myself.	1	2	3	4
10. I can't do all the things normal people do because it's too easy for me to get injured.	1	2	3	4
11. No one should have to exercise when he/she is in pain.	1	2	3	4



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NAME: _____ DATE: _____

Quick DASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors)	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.)	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, <i>to what extent</i> has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. (circle number)	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? (circle number).	1	2	3	4	5

WORK MODULE (OPTIONAL)

The following questions ask about the impact of your arm, shoulder or hand problem on your ability to work (including homemaking if that is your main work role).

Please indicate what your job/work is: _____

I do not work (You may skip this section.)

Please circle the number that best describes your physical ability in the past week.

Did you have any difficulty:	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Using your usual technique for your work?	1	2	3	4	5
2. Doing your usual work because of arm, shoulder or hand pain?	1	2	3	4	5
3. Doing your work as well as you would like?	1	2	3	4	5
4. Spending your usual amount of time doing your work?	1	2	3	4	5

SPORTS/PERFORMING ARTS MODULE (OPTIONAL)

The following questions relate to the impact of your arm, shoulder or hand problem on playing *your musical instrument or sport or both*. If you play more than one sport or instrument (or play both), please answer with respect to that activity which is most important to you.

Please indicate the sport or instrument which is most important to you: _____

I do not play a sport or an instrument (You may skip this section.)

Did you have any difficulty:	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Using your usual technique for playing your instrument or sport?	1	2	3	4	5
2. Playing your musical instrument or sport because of arm, shoulder or hand pain?	1	2	3	4	5
3. Playing your musical instrument or sport as well as you would like?	1	2	3	4	5
4. Spending your usual amount of time practicing or playing your instrument or sport?	1	2	3	4	5

MDC 10 (90% CL)
12.75 (95% CL)