Injury Wellness Center

208- 5401 Temple Dr. N.E., Calgary, Alberta, T1Y-3R7, Canada

Phone: 587-500-1202, Fax: 403-454-3129, info@injurywellnesscenter.ca

**CONFIDENTIAL PATIENT INFORMATION SHEET**

**PERSONAL HISTORY**

Name: First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of birth:\_\_\_/\_\_\_/\_\_\_(MM/DD/YY)

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Business\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact (Name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact (# or address):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How were you referred to our facility?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this related to a motor vehicle accident (MVA)? Yes No

Insurance company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Claim/Policy No.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Extended Health Insurance: No Yes If yes, please indicate the details:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever received treatment at another Physiotherapy Clinic before? No Yes

If yes, where? (Name of the Clinic)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Working before accident? No Yes If Yes, Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Working after accident? No Yes If Yes, Name of company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you Primary caregiver? No Yes How many children? \_\_\_\_\_\_\_ Ages?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you able to perform housekeeping after the accident? No Yes

**ACCIDENT DETAILS**

Where you a: Driver Passenger Pedestrian Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Accident (MM/DD/YY): \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ What time did the accident occur? \_\_\_\_\_\_\_:\_\_\_\_\_\_\_\_\_(a.m./p.m.)

Give a brief description of the accident and what happened to you.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Reason for traveling (e.g. going to work, visiting family etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who was in the car with you? (Passengers, if applicable)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Car driven at the time of the accident? (ride off/fixed)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where you a seat-belted driver/passenger? Yes No

Where did the accident occur? (Please be specific: address, street, intersection, city, and province)

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How was the weather that day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Impact of your vehicle (rear-ended, front, side)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your airbags deploy? No Yes

Immediately after the impact, what are your injuries? (please describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Did you lose consciousness? No Yes (how long?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did a police or ambulance come to the scene? No Yes

Were you brought to the hospital after? No Yes

Did you have an X-Ray done? No Yes

**CURRENT HEALTH HISTORY**

Current concern(s) and when they are started- in order of importance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Rate your pain now (None) 1 2 3 4 5 6 7 8 9 10 (Worst)

Have you had this injury before? No Yes If yes, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had previous treatment? No Yes If yes, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications, supplements (vitamins, etc) you are currently taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medical conditions you have been diagnosed with (e.g. diabetes, heart disease, cancer, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear orthotics? No Yes If yes, how long have you had them?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much sleep do you get per night?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| **HEAD TO TOE CHECKLIST** | **YES** | **COMMENTS** |
| **HEAD AND FACE** |
| Head bumps or bruise |  |  |
| Headache  |  |  |
| Blurry Vision |  |  |
| Bruise on the face |  |  |
| Do you have pain in your forehead? |  |  |
| Do you have pain at the back of your head? |  |  |
| Hearing problems |  |  |
| Jaw pain/tenderness |  |  |
| Clicks on the jaw when talking or chewing Left or Right? |  |  |
| **NECK** |
| Bruise on the neck Left or Right? |  |  |
| Pain and Tenderness Left or Right? |  |  |
| Clicks on the neck when turning side to side |  |  |
| **SHOULDER** |
| Bruise on the shoulder Left or Right? |  |  |
| Pain and Tenderness Left or Right? |  |  |
| **UPPER EXTREMITIES** |
| Bruise on the arms Left or Right? |  |  |
| Pain and Tenderness on arms Left or Right? |  |  |
| Numbness on arms Left or Right? |  |  |
| Bruise/Fractures on the elbow Left or Right? |  |  |
| Pain on elbow when bending and extending? Left or Right? |  |  |
| Bruise on the wrist Left or Right? |  |  |
| Numbness on the forearm Left or Right? |  |  |
| Hand pain? |  |  |
| Hand numbness Left or Right? |  |  |
| **CHEST** |
| Bruise on the Chest |  |  |
| Pain on the Chest |  |  |
| Difficulty in Breathing |  |  |
| **ABDOMINALS** |
| Pain and Tenderness |  |  |
| Upper left Upper right Lower left Lower right |  |  |
| **BACK** |
| Bruise in the back |  |  |
| Pain and Tenderness High Mid Low? |  |  |
| **LOWER EXTREMITIES** |
| Bruise/Fracture in the hip? |  |  |
| Pain and Tenderness in the hip |  |  |
| Pain when sitting |  |  |
| Bruise on the thing Left or Right? |  |  |
| Pain and Tenderness in the hip Left or Right? |  |  |
| Bruise on the knee Left or Right?  |  |  |
| Pain and Tenderness in the knee Left or Right? |  |  |
| Bruise on the Leg Left or Right? |  |  |
| Pain and Tenderness on the leg Left or Right? |  |  |
| Pain and Tenderness on the ankle Left or Right? |  |  |
| Numbness Thing Leg Foot |  |  |

**Other:** (any other complaints that were not asked, but you wanted us to know. E.g. sleeping problems, fear of driving, loss of appetite, etc.)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST HEALTH HISTORY**

List any previous Surgeries and the year(s) they occurred\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any previous Fractures and the year(s) they occurred\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any previous Accident/traumas and the year(s) they occurred\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check off all applicable conditions you are experiencing or have experienced:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have completed the form to the best of my knowledge and I agree to share this information to the clinic and the health professionals involved in my treatment, I will also notify them if any conditions change.

Client’s signature Date