ACTIVEREHAB CENTRE

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REGISTRATION FORM

PLEASE HAVE A PIECE OF PHOTO ID, AND YOUR INSURANCE CARD READY & HAND THEM TO THE RECEPTIONIST WHEN YOU ARE FINISHED

PATIENT INFORMATION

*Last name:	*First name:	Middle name:
Title: (Circle one) Mr. Mrs. Ms. Miss Other: _____	*Sex: (Circle one) Male Female Prefer not to answer	*Age: *Birth date: M: D: Year:
Height: (Please note the unit as well – cm, ft, etc.)	Weight: (Please note the unit as well – lbs, kgs, etc.)	Shoe size: (Please note the unit as well – US, EU, etc.)

*Address:

12345 STREET ADDRESS UNIT # CITY PROVINCE POSTAL CODE

*Email:	*Phone no.:	Secondary phone no.:

Preferred Method(s) of Contact: ☐ Email ☐ Phone ☐ Text Message

Family Doctor name:	Family Doctor Phone no.:	Other contact info for Family Doctor:

Chose clinic because/referred to clinic by:

- ☐ Close to Home/Work
- ☐ Family — Who:
- ☐ Friend — Who:
- ☐ Doctor Referral — Who:
- ☐ Sign
- ☐ Newspaper/Flyer — Which one:
- ☐ Internet — How:
- ☐ Other: _____

Other family members seen here:

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Phone no.:	Secondary phone no.:

INSURANCE INFORMATION

*Are you covered by an insurance plan? i.e.: Through work or privately, etc.:

Yes No More than 1

Primary Insurance Details

You may skip this section if you selected *No* above.

*Please indicate the insurance company:

Occupation:

Employer:

*Relationship to holder:
(Circle one)

Self Spouse Child

Other: _____

If the holder is someone other than Self, or your name is different on your card:

*Last name:

*First name:

*Group/Plan no.:

*Certificate/Member no.:

*Birth date:

M: D: Year:

Secondary Insurance Details

You may skip this section if you have coverage with only one insurance plan.

*Please indicate the insurance company:

Occupation:

Employer:

*Relationship to holder:
(Circle one)

Self Spouse Child

Other: _____

If the holder is someone other than Self, or your name is different on your card:

*Last name:

*First name:

*Group/Plan no.:

*Certificate/Member no.:

*Birth date:

M: D: Year:

MVA INSURANCE INFORMATION

Name of the MVA insurance company:

Address of the MVA insurance company:

12345 STREET ADDRESS UNIT # CITY PROVINCE POSTAL CODE

Adjuster Name:

Adjuster Phone no.:

Adjuster Fax no.:

Policy no.:

Claim no.:

*Relationship to Policy Holder:
(Circle one)

Self Spouse Child

Other: _____

If the holder is someone other than Self:

*Last name:

*First name:

ACCIDENT INFORMATION

*DOL:
(Date of accident)

Month: Date: Year:

*Please provide a brief description of how the accident occurred:

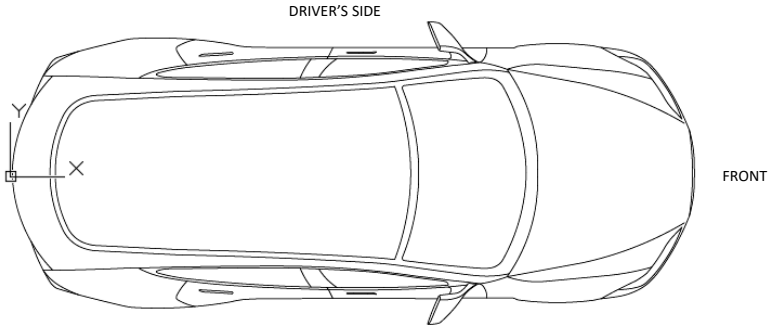
*You were:

☐ The Driver ☐ A Passenger ☐ On a Motorcycle ☐ Riding a Bicycle ☐ A Pedestrian

Where were you seated?:

☐ Driver's Seat ☐ Front Passenger ☐ Rear – Left ☐ Rear – Right ☐ Rear – Middle

Where was your vehicle impacted?:
(Please circle or mark the appropriate area)



What were the weather conditions?:

☐ Clear ☐ Wet ☐ Snow ☐ Icy

Did you hit your head?:	Did you lose consciousness?:	Were you able to get out unassisted?:
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

INJURY INFORMATION

*What is your major symptom/concern?:

*When did your symptoms begin?:	*Have you had this problem before?:	*Is your condition getting progressively worse?:

*This problem is:

☐ Constant
☐ Comes and goes

*What is the severity of your pain on a scale of 0-10?:
(Circle one)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

*How does it feel?:

☐ Aching ☐ Burning ☐ Dull ☐ Sharp ☐ Shooting
☐ Stiff ☐ Swelling ☐ Tingling ☐ Throbbing ☐ Other: _____

What makes your condition better?:	What makes your condition worse?:

Have your injuries during this accident affected your:

☐ Work ☐ Recreational Activities/Sports ☐ Home Life ☐ Sleep

Have you received treatment for this injury?:	Are you currently receiving treatment from another health care professional?:
☐ No ☐ Yes – if yes, where? _____	☐ No ☐ Yes – if yes, what? _____

Are you currently taking any medications?:

☐ No ☐ Yes – if yes, what? _____

MEDICAL HISTORY & INFORMATION

***Have you had any (Please note the date if yes to any of the below, and any relevant details):**

Automobile accidents?:	Surgeries?:	Broken bones?:	Falls/Major injuries?:

Internal pins, wires, artificial joints or special equipment?:

Are any of the following stressors a constant in your life (Please note the intake/relevant information if yes to any of the below):

Smoking?:	Alcohol?:	Coffee/Caffeinated Drinks?:	High Stress Level?:
(Please note your intake – ex: packs/day)	(Please note your intake – ex: drinks/week)	(Please note your intake – ex: cups/day)	(Please note the reason)

*Please check any of the following conditions you have/had:

- ☐ Aids/HIV
- ☐ Allergies
- ☐ Anxiety/Depression
- ☐ Arm/Shoulder Pain
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic Cough
- ☐ Chronic Fatigue
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Ear Problems
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Haemophilia
- ☐ Headaches/Migraines
- ☐ Hearing Loss
- ☐ Heart Attack/Disease
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Herniated Disk
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Insomnia
- ☐ Irregular Cycle
- ☐ Kidney Problems
- ☐ Leg Pain
- ☐ Loss of Sensation
- ☐ Low Blood Pressure
- ☐ Lower Back Pain
- ☐ Mental Illness
- ☐ Neck Pain
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Poor Circulation
- ☐ Prostate Problems
- ☐ Sciatica
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Sinus Infection
- ☐ Skin Conditions
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ TB
- ☐ TMJ
- ☐ Varicose Veins
- ☐ Venereal Disease
- ☐ Vertigo/Dizziness
- ☐ Other: _____

Family History of:

- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Problems
- ☐ High/Low Blood Pressure
- ☐ Respiratory Conditions

FEMALES

*Are you pregnant?:

☐ Yes ☐ No

Activities that are painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Bending ☐ Getting Up ☐ Driving ☐ Reading

Do you have any gynecological conditions?:

☐ No ☐ Yes – if yes, what? _____

SYMPTOMS			
Please check all that apply:	**BEFORE** the collision	**IMMEDIATLEY AFTER** the collision	**CURRENTLY** experiencing
Neck pain and/or stiffness			
Shoulder or Arm pain and/or stiffness			
Arm or Hand weakness and/or tingling			
Upper Back pain/stiffness			
Mid Back pain/stiffness			
Lower Back pain/stiffness			
Hip or Leg pain/stiffness			
Headaches			
Jaw, Tooth, or **Ear** pain			
Loss of co-ordination			
Dizziness			
Vision affected			
Ringing in the ears and/or **Hearing loss**			
Difficulty swallowing and/or **Speaking**			
Nausea and/or **vomiting**			
Trouble concentrating and/or **Memory loss**			
Sleep and/or **Personality Changes**			
Numbness, where: _____			
Other: _____			

AGREEMENT

The above information is true to the best of my knowledge. I acknowledge that any treatment fees not covered by the MVA insurance will be my responsibility. I authorize Active Rehab Centre or the insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature Date