TINA GOUTSOS
ATHLETIC THERAPY

50-1580 Taylor Ave | Winnipeg | R3N 2A7 P. 204-504-life(5433) F. 204-414-4876
website: www.thrivechiropractic.ca | email: goutsosathletictherapy@gmail.com

Tina Goutsos CAT(C) Certified Athletic Therapist

ATHLETIC THERAPY - NEW PATIENT INTAKE FORMS

Please compete these forms as fully and carefully as possible. Your answers will help us process your file to determine the nature of your complaint, and how to best assist you. This information will remain strictly confidential. ***Date:***_____

Last Name (Middle Initial) | First Name Sex: M / F

Date of Birth: dd/mm/yyyy | How did you hear about our office?

( ) Cell Phone | ( ) Home Phone | ( ) Work Phone | Extension number

Address (#, Street Name) | City, Prov. Postal Code

Occupation | Email Address

AUTHORIZATION FOR CARE OF A MINOR (UNDER 18 YEARS Of AGE)

I hereby authorize and consent to an Athletic Therapy evaluation and subsequent treatment of my child.

Name of Parent / Guardian: _____ Contact #: (____)_____

Signature: _____ Date: _____

Is this a Worker's Compensation Case? ☐ Yes ☐ No

If yes, date of Injury? _____ Type of Injury?_____ Claim #_____

Name and phone # of Adjuster: _____

Did your complaint(s) arise from a Motor Vehicle Accident (MPI)? ☐ Yes ☐ No

If yes, date of Injury? _____ Collision Type (i.e. rear-ended)_____

Name and phone # of Adjuster:_____ Claim # _____

MEDICAL INFORMATION

Name of Family Doctor: _____ Clinic Name / Location: _____

Date of Last Physical?_____ Presence of: ☐ *Pacemaker* ☐ *Artificial Joints* ☐ *Internal Wires/Pins*

Have you taken Tylenol, Advil or other over the counter pain medication in the last 48 hours? ☐ Yes ☐ No

Have you undergone advanced imaging? ☐ Yes ☐ No

If yes, please check off all that apply: ☐ X-ray ☐ CT scan ☐ MRI ☐ Bone Scan.

Please list **date** : _____ and **where** imaging was completed_____

Please list all current medications:

_____

List and date any major surgeries and / or hospitalizations/ major medical conditions:

_____

PAIN DRAWING

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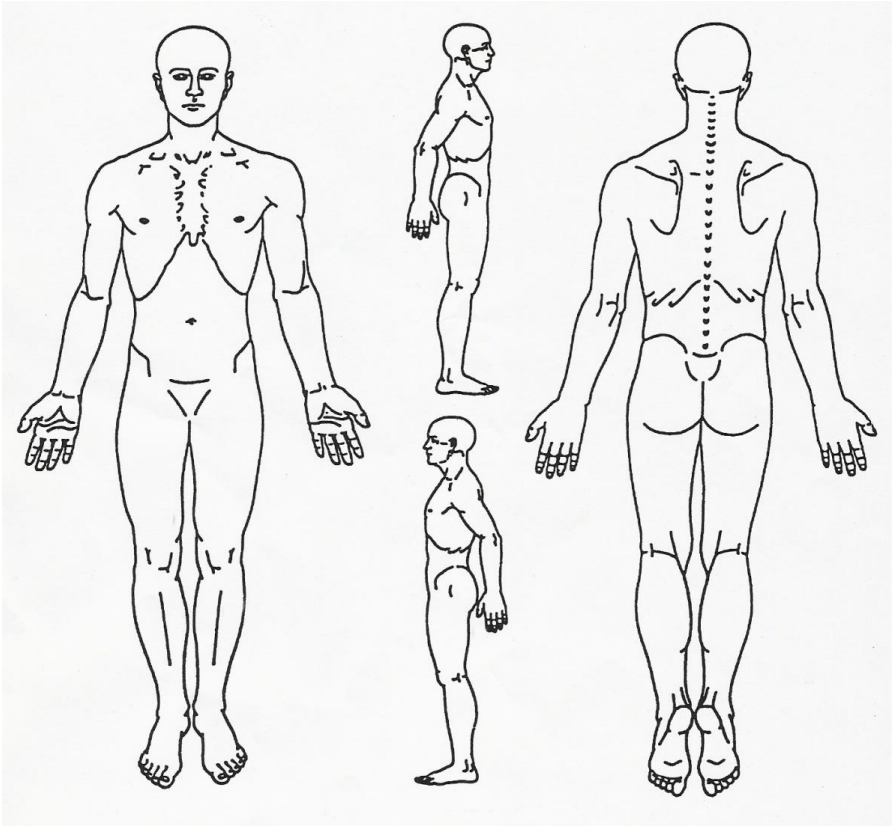
Please circle your area of complaint(s) on diagram and indicate the type of pain/discomfort (A=*Achy, D=Dull, S=Sharp/Stabbing, B=Burning, N=Numbness, P=Pins and Needles, or Other*:_____) next to the area.



Please indicate how you would CURRENTLY rate your pain.
(LOW) 0 1 2 3 4 5 6 7 8 9 10 (HIGH)

If complaint is due to an action or event, please explain:
_____
_____

Did your complaint(s) come on: ☐ Suddenly, ☐ Gradually
How long have you been you been experiencing pain for? ____ Days, ____ Weeks, ____ Months.
Is the condition worse in the: ☐ AM ☐ PM ☐ No change
Is the complaint: ☐ Constant ☐ Intermittent ☐ Worse with movement

What aggravates your condition / pain?
_____
What (if anything) relieves your condition / pain?
_____

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Athletic Therapy Consent Form

I acknowledge and understand that my therapist must be aware of any existing medical conditions. I have completed my medical history form as provided by my therapist. The information I have provided is true and complete to the best of my knowledge.

Signature: _____

FEES AND SERVICES.
Payment for services are the responsibility of the patient and are to be paid for at each visit. If a third party payer (ie.WCB, MPI) denies my claim and/or refuses to pay for the full amount billed, I am responsible for paying the outstanding amount. I understand that I am responsible for any reimbursement provided by any other private insurance companies, ie. Great West Life, Manulife etc.

CANCELLATION & NO SHOW POLICY.
In consideration of other Clients and the Athletic Therapist, I understand that a minimum of 24 hours notice is required to change or cancel my appointment. I am aware a **$25 fee** will be applied to my account in the occurrence of late cancellations or missed appointments. (medical emergencies excluded)

CONSENT FOR COMMUNICATION / RELEASE OF INFORMATION
I hereby authorize and grant permission to the above-named Athletic Therapist to communicate with other health care professionals involved in my care, such as my Physician, Chiropractor and / or Insurance Case Managers.

CONSENT FOR ASSESSMENT & TREATMENT.
I understand that my Athletic Therapist, is providing athletic therapy services within their scope of practice as defined by the Canadian Athletic Therapist Association. I consent to participate in the recommended assessments, treatments and rehabilitation Athletic Therapy services provided by Tina Goutsos - Athletic Therapy at Thrive Chiropractic.
I understand that my Athletic Therapist will collaborate with me in making decisions regarding my assessment and treatment. I acknowledge that with any treatment there can be risks, those risks have been explained to me and I assume such responsibility as well as the potential of forgoing the suggested care. I should discuss any questions or concerns about my treatment and rehabilitation with my Athletic Therapist.
I have read and understand the conditions as provided above and I am in agreement with all of the above information.

Signature: _____ Date:_____

In the event of private insurance coverage, I understand that all services, including Acupuncture, are to be claimed under Athletic Therapy Coverage. I am responsible to verify if Athletic Therapy is included in my insurance plan.

Initials_____