"WHERE EVERYONE IS TREATED LIKE A PRO!"

MEDICAL ASSESSMENT FORM

(Please Print)

PATIENT INFORMATION						
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Date of Birth: dd/mm/yyyy	
Street Address:		Unit or Apartment #:		City:		Postal Code:
Sex: ❑ M ❑ F	Home Phone Number: ( )		Cell Phone Number: ( )		Work Phone Number: ( )	
E-Mail Address:			Occupation:			

MEDICAL INFORMATION				
Family Doctor:	Phone Number: ( )		Practice Location:	
Current Medications:				
Please list and date any Surgeries:				
Please list the presence of any internal pins, wires and artificial joints:				
Is this Condition:	❑ Motor Vehicle Accident	❑ WSIB	❑ Sports Injury	❑ Other: _____
What is your Chief Complaint:				
Any other areas of Concerns:				

Progressive Sports Medicine
1179 Northside Road, Burlington, ON, L7M 1H5
Phone: (905) 336-7707 Fax: (905) 336-7737
www.progressivesportsmedicine.ca e-mail: info@progressivesportsmedicine.ca

❍ Chiropractic
❍ Massage Therapy
❍ Orthotics
❍ Physiotherapy
❍ Acupuncture
❍ Laser Therapy
❍ Athletic Therapy
❍ Clinical Conditioning

MEDICAL HISTORY

Cardiovascular

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chronic Heart Failure
- ❑ Heart Disease
- ❑ Myocardial Infarction
- ❑ Phlebitis
- ❑ Cardio-Vascular Accident
- ❑ Stroke
- ❑ Pacemaker
- ❑ Varicose Veins
- ❑ Blood Clots
- ❑ Osteoarthritis
- ❑ Lymphedema
- ❑ Other: _____

Respiratory

- ❑ Chronic Cough
- ❑ Bronchitis
- ❑ Shortness of Breath
- ❑ Asthma
- ❑ Emphysema
- ❑ Smoking
- ❑ Other: _____

Infectious Diseases

- ❑ Hepatitis
- ❑ Tuberculosis
- ❑ HIV
- ❑ Other: _____

Digestive

- ❑ Constipation
- ❑ Gas/Bloating
- ❑ Nausea/Vomiting
- ❑ Irritable Bowel Syndrome
- ❑ Liver/Gall Bladder
- ❑ Kidney/Bladder

Nervous System

- ❑ Herpes/Shingles
- ❑ Numbness/Tingling
- ❑ Chronic Pain
- ❑ Fatigue
- ❑ Sleep Disorder
- ❑ Loss of Sensation
- ❑ Other: _____

Musculo-Skeletal

- ❑ Bone or Joint Disease
- ❑ Tendonitis
- ❑ Bursitis
- ❑ Fractures
- ❑ Osteoporosis
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Sprains/Strains
- ❑ Swelling
- ❑ Stiffness
- ❑ Headaches
- ❑ Migraines
- ❑ Spasms/Cramps
- ❑ Pain (check area):

_Jaw _Neck _Shoulder _Elbow _Wrist
_Hip _Knee _Ankle _Back _Foot _Toes

Skin

- ❑ Allergies (anaphylactic)
- ❑ Rashes
- ❑ Athletes Foot
- ❑ Warts
- ❑ Cold Sores
- ❑ Eczema/Psoriasis
- ❑ Other: (contagious)

_____

Reproductive

- ❑ Pregnancy (trimester___)
- ❑ PMS
- ❑ Other: _____

Other

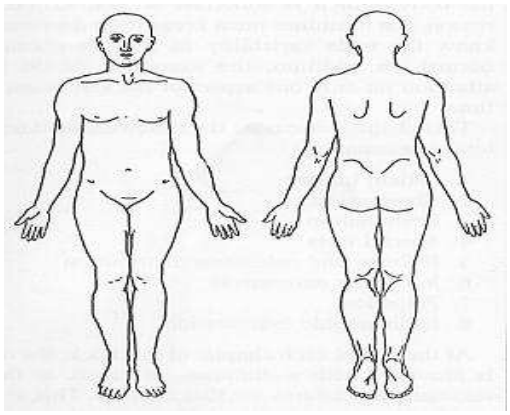
- ❑ Drug/Alcohol addiction
- ❑ Nicotine/Caffeine addiction
- ❑ Diabetes
- ❑ Vision/Hearing Loss
- ❑ Headaches/Migraines
- ❑ Cancer
- ❑ Epilepsy
- ❑ Allergies (please list)
- ❑ Other: _____

INDICATE AREAS OF PAIN OR DISCOMFORT

Mark the areas on the bodies where you feel the described sensations.

Indicate areas of:

Numbness **))))**
Pins & Needles **OOOO**
Burning **XXXX**
Aching ****
Stabbing **////**



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Release of Medical and Other Information

Release of Information:

I hereby authorize Progressive Sports Medicine Inc. and/or its employees or agents to be permitted to obtain and review copies of all medical, hospital, clinical, and practitioner's notes; employment, vocational, and insurance documents, including full and final or other releases, and any other related records or documents, and to share or discuss pertinent information with appropriate qualified medical & paramedical professionals or others involved in my treatment, rehabilitation, claims or representation. I hereby give my permission for Progressive Sports Medicine and/or its employees or agents to share the information received with any other duly authorized individuals or parties acting in accordance with my representative's permission. I agree that a photocopy of this authorization be accepted if necessary.

Dated this _____ day of_____,20_____.

_____ _____

Patient Signature (Legal Guardian) Name (*Please Print*)

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