

Last Name: _____ First Name: _____ Age: _____

Date of Birth: _____ Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

How would you prefer to be notified of your upcoming appointments? Text Email

Address: _____

City: _____ Province: _____ Postal Code: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Manitoba Health No.: _____ Personal Health ID: _____

Family Physician: _____ Date of last physical: _____

Insurance provider: _____ WCB/MPI Claim #: _____

Insurance contract #: _____ Insurance group #: _____

Policy holder: _____ Relation: _____ Phone: _____

How were you referred to Victory?

Doctor (name): _____ Another client/friend (name): _____

Website Social Media Advertisement Event Hospital/Clinic Gym Other

In order to ensure you quality service, we ask you to read the following:

1. We require AT LEAST 24 HOURS notice to change or cancel your appointment. If we don't receive sufficient notice, you will be responsible for the FULL COST of the missed visit. This notice allows us to offer your appointment to someone else and allows your therapist to adjust his/her schedule for that day.

2. We ask that you arrive 5 MINUTES prior to your appointment time.

3. Victory direct bills to Manitoba Blue Cross, MPI and WCB. For all other coverage, we will provide you with proper documentation to submit to your insurance company.

4. Please check with your insurance company for your coverage. It is your responsibility to obtain a **medical referral**, if required by your insurance coverage. You are responsible for the FULL AMOUNT of your treatments at Victory. All invoices are payable upon receipt.

I, the undersigned, authorize Victory Therapy & Sports Injury Clinic to commence treatment. I understand that injuries can arise by accident from the very nature of training activities, and hereby waive all rights to any claim or actions against Victory Therapy & Sports Injury Clinic, arising from injury, loss or damage to me or to my child's property. **I have read and understand the above terms and conditions.**

I hereby authorize Victory to release information pertaining to my treatment to: _____

Client or Guardian signature

Date

Name: _____

Date of injury or surgery (if applicable): _____

Have you ever suffered or currently suffer from any of the following conditions?:

- Cardiac problems yes no
- Pacemaker/defibrillator yes no
- Angina yes no
- High/low blood pressure yes no
- Respiratory problems yes no
- Osteoarthritis yes no
- Osteoporosis yes no
- Rheumatoid Arthritis yes no
- Bone/joint disease yes no
- Multiple Sclerosis yes no
- Muscular disorders yes no
- Diabetes yes no
- Hepatitis yes no
- Communicable disease/HIV yes no
- Blood disorder yes no
- Hyper/Hypothyroidism yes no
- Disorder of internal organs yes no
- Bowel/bladder problems yes no
- Recent weight loss yes no
- Increased painful cough/sneeze yes no
- Mental illness yes no
- Anxiety/depression yes no
- High-dose steroids yes no
- Night pain/sweats yes no
- Dizziness yes no
- Headaches yes no

Breaks/fractures yes no

Bone(s): _____

Date(s): _____

History of cancer yes no

Type(s): _____

Date(s): _____

Surgeries yes no

Type(s): _____

Date(s): _____

Heart attack yes no

Date(s): _____

Stroke yes no

Date(s): _____

X-Ray, MRI, CT scan, DxUS yes no

For what: _____

Date(s): _____

Allergies yes no

List: _____

Pregnancy yes no No. weeks:

Other medical conditions: _____

Medications/herbal remedies: _____

Internal notes: