



“WHERE EVERYONE IS TREATED LIKE A **PRO!**”

MEDICAL ASSESSMENT FORM

(Please Print)

PATIENT INFORMATION						
Patient's last name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Date of Birth: dd/mm/yyyy
Street Address:			Unit or Apartment #:	City:	Postal Code:	
Sex: <input type="checkbox"/> M <input type="checkbox"/> 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:	<input type="checkbox"/> Motor Vehicle Accident	<input type="checkbox"/> WSIB	<input type="checkbox"/> Sports Injury
<input type="checkbox"/> 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

- | | | |
|---------------------------------------|-------------------------------------|---|
| <input type="radio"/> Chiropractic | <input type="radio"/> Physiotherapy | <input type="radio"/> Athletic Therapy |
| <input type="radio"/> Massage Therapy | <input type="radio"/> Acupuncture | <input type="radio"/> Clinical Conditioning |
| <input type="radio"/> Orthotics | <input type="radio"/> Laser Therapy | |

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: _____

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: _____

Skin

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

Reproductive

- Pregnancy (trimester____)
- PMS
- Other: _____

Respiratory

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

Infectious Diseases

- Hepatitis
- Tuberculosis
- HIV
- 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

Other

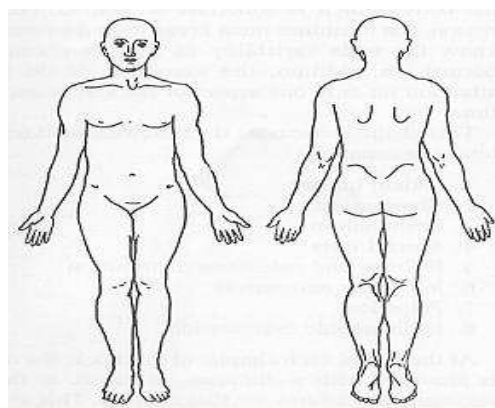
- Drug/Alcohol addiction
- Nicotine/Caffeine addiction
- Diabetes
- Vision/Hearing Loss
- Headaches/Migraines
- Cancer
- Epilepsy
- Allergies (please list)
- Other: _____

INDICATE AREAS OF PAIN OR DISCOMFORT

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

Indicate areas of:

Numbness))))
 Pins & Needles 0000
 Burning XXXX
 Aching ****
 Stabbing ////



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 Physiotherapy Athletic Therapy
 Massage Therapy Acupuncture Clinical Conditioning
 Orthotics Laser Therapy

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*)

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

- | | | |
|---------------------------------------|-------------------------------------|---|
| <input type="radio"/> Chiropractic | <input type="radio"/> Physiotherapy | <input type="radio"/> Athletic Therapy |
| <input type="radio"/> Massage Therapy | <input type="radio"/> Acupuncture | <input type="radio"/> Clinical Conditioning |
| <input type="radio"/> Orthotics | <input type="radio"/> Laser Therapy | |