

**Medical History Form**

\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 First Name Last Name Alberta Health Care Number Birth Date (dd/mm/yy)  
 \_\_\_\_\_  
 Address City Postal Code  
 \_\_\_\_\_  
 Home Ph. # Cell Ph. # Business Ph. # Email Address  
 \_\_\_\_\_  
 Emergency Contact Ph. # Doctor's Name

**Private Insurance**  Yes  No **Insurance Company Name** \_\_\_\_\_

<b>Covered Member Name/Member Number</b>	_____
<b>Group Number</b>	_____
<b>Section Number</b>	_____
<b>Member Number (patient)</b>	_____

**How did you hear about the clinic?**  Friend/Relative  Doctor  Dentist  Mail out advertisement  
 Yellow Pages  Google  Canpages  Live in the area

**Were you ever treated for any of the following? (please check all that apply)**  
 Stroke  Heart Disease  Rheumatoid Arthritis  Epilepsy  Respiratory Problems  Diabetes  
 Migraines  Hemophilia  Hepatitis A  Hepatitis B  Hepatitis C  HIV

**Do you have any of the following? (please check all that apply)**  
 Dizzy spells  Fractures  Metal Implants in the body  Pacemaker

**Are you pregnant (if applicable)**  yes  no **What medications are you currently taking?** \_\_\_\_\_

**For Motor Vehicle Accident Patients (if this does not apply to you, please skip this section)**

\_\_\_\_\_  
 Motor Vehicle Insurance Company Adjustor Phone Number  
 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Policy Number Claim Number Date of Accident (dd/mm/yy)

**For Worker's Compensation Board Patients (if this does not apply to you, please skip this section)**

\_\_\_\_\_  
 Name of company you are employed with Address of company you are employed with Supervisor name and phone #  
 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Name of Doctor/Clinic visited for this injury Job Title Date of Accident (dd/mm/yy) WCB Claim Number

**Treatment costs will be billed directly to the Patient/WCB/or Insurance Company. The cost paid by the patient may be recovered through private insurance plans (ex. Blue Cross) or may be claimed as a medical expense when filing personal income tax. We would ask you to sign below in acknowledgement and understanding of your responsibility for costs for treatments.**  
**I authorize and grant permission to the physiotherapist(s) of Belmead Physical Therapy to perform an assessment and provide treatment which may include some of the following but is not exclusive to: Thermal agents, electrical modalities, manual therapy techniques, spinal manipulation, exercise prescription, acupuncture, and intramuscular stimulation (IMS).**

\_\_\_\_\_  
 Signature Date