Banff Sport Medicine

Patient Registration

Health Care	Number	Province	Expiry Date (if applicable)	**Today's Date**	
Name	***As it appears on your Health Care Card***				
	Full Name - *if **different** than name on Health Care Card*				
Date of Birth	Day / Month / Year			**Age**	**Sex**
Address	Street/Mailing				
	City/Town	Province	Postal Code		

Email	Primary Email	☐ Personal ☐ Work ☐ Other	Secondary Email	☐ Personal ☐ Work ☐ Other
Contact Number	Primary Phone Number	☐ Cell ☐ Home ☐ Work ☐ Other	Secondary Phone number	☐ Cell ☐ Home ☐ Work ☐ Other
Occupation	Job Title	Employer	Phone Number	

Family Doctor	Name	Clinic Name/Location	Phone Number
Emergency Contact	Name	Relationship	Phone Number

Is this a work-related injury?	☐ **NO,** *if no skip section.* ☐ **YES,** *if yes please answer the following questions.*

Date of Injury:	Location:
Employer at time of injury:	
Nature of injury:	
Social Insurance Number:	WCB Claim Number:

Banff Sport Medicine Uninsured Services Policy: Fees for uninsured services (not covered under provincial health care plans) will be at the discretion of the physician. This includes but is not limited to forms required by third parties and government agencies.

rev. Jan 22, 2018

Banff Sport Medicine
207-303 Lynx St / PO Box 1300 Banff AB T1L 1B3
P: 403 760 2897 F: 403 760 8234

Banff Sport Medicine - Canmore Clinic
187 Kananaskis Way Canmore AB T1W 0A3
P: 403 678 1271 F: 403 621 1932

www.banffsportmed.ca

Banff Sport Medicine

SHOULDER: Initial Consult

PATIENT HISTORY

PATIENT NAME: _____ Height _____ Weight_____ Date_____

Symptoms / Injury Description

Which SHOULDER are you being seen for today? ☐ Right ☐ Left ☐Both

Did your problem come on gradually or as a result of an injury? ☐ Gradually Date of onset: _____

☐ Injury Date of injury: _____

Describe what happened: _____

_____

The main problem is? ☐ Pain ☐ Instability ☐ Stiffness ☐ Weakness ☐ Other_____

Rate your shoulder problem during the last month: (no problem) 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ (worst)

Does your shoulder wake you up at night? ☐ Yes ☐ No

What, if anything, makes your shoulder worse? _____

What, if anything, makes your shoulder better? _____

Sports / Recreation

List your regular sports/recreation activities:

1. _____ ☐ Recreational ☐ Amateur Competitive ☐ Professional Competitive ☐ Other_____

2. _____ ☐ Recreational ☐ Amateur Competitive ☐ Professional Competitive ☐ Other_____

Previous Surgery / Treatments / Tests

Have you had previous?:

RIGHT: Shoulder **injuries?** ☐ Yes ☐ No	**LEFT:** Shoulder **injuries?** ☐ Yes ☐ No
Describe:	Describe:
When?	When?
RIGHT: Shoulder **surgeries?** ☐ Yes ☐ No	**LEFT:** Shoulder **surgeries?** ☐ Yes ☐ No
Describe:	Describe:
When?	When?

What treatment(s) have you had for your shoulder? ☐ Nothing ☐ Physiotherapy ☐ Medication ☐ Injections

☐ Sling ☐ Surgery ☐ Other: _____

What tests have you had done for your shoulder? ☐ X-ray ☐ MRI ☐ CT scan ☐ Ultrasound ☐ Bone Scan

MEDICAL HISTORY

Medication _____

_____

Allergies _____

_____

Medical Conditions

Heart ❑ _____

Lungs ❑ _____

Kidneys ❑ _____

Diabetes ❑ _____

Other ❑ _____

Major Surgeries ❑ _____

Anaesthetic Complications ❑ _____

Bleeding Disorders ❑ _____

Do you smoke? Yes ❑ No ❑ If yes, how much? _____

Do you drink? Yes ❑ No ❑ If yes, how much? _____

Please note that there is a $15.00 minimum fee for "EACH" unemployment and or private insurance form completed by the attending physician.
This must be paid before we will release the completed form

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Consent for Release of Information:

Instructions:

1.) In situations other than those specifically excluded in Section 40 of the Hospitals Act, this form must be signed by the patient prior to releasing and/or obtaining information about him/her.

2.) When requesting information, this form must be accompanied by a covering letter which indicates what information is requested.

I, _____

Hereby authorize the Calgary Health Region to:

1.) ☐ Obtain from (specific persons, institutions, agencies)

2.) ☐ Release to (specific persons, institutions, agencies)

Information about myself, including my medical record subject to the following exclusions:
(list here – if any)

This consent is given for a period of 6 months from the date hereof:

Date dd/Mmm/yyyy

Signature

Witness

Printed Name: