



BOOKING Phone: 403.984.1445 | Fax: 403.984.1446 | Email: info@mskrehab.org | www.mskrehab.org

PATIENT INFORMATION

Name: _____ ☐ F ☐ M ☐ O
 Address: _____
 City/Province: _____ Postal Code: _____

Home Phone: _____
 Work/Mobile Phone: _____
 Date of Birth (D/M/Y): _____
 AHC: _____ WCB: _____

CLINICAL HISTORY

WHAT WOULD YOU LIKE US TO HELP WITH?

- | | |
|---|---|
| ☐ Pain Reduction | ☐ Exercise Therapy |
| ☐ Restore Mobility | ☐ Dry Needling/Gunn IMS |
| ☐ Improve Strength | ☐ Concussion |
| ☐ Return to Work | ☐ Headache Management |
| ☐ Return to Sport | ☐ Motor Vehicle Accident |
| ☐ Manual Therapy | ☐ Post-operative Rehab |
| ☐ Chronic Pain | ☐ Other: _____ |

REGION

(Axial)

- | | |
|--|-------------------|
| ☐ R ☐ L | CRANIUM |
| ☐ R ☐ L | TEMPOROMANDIBULAR |
| ☐ R ☐ L ☐ C | CERVICAL SPINE |
| ☐ R ☐ L ☐ C | THORACIC SPINE |
| ☐ R ☐ L ☐ C | LUMBAR SPINE |
| ☐ R ☐ L | SACROILIAC |

(Peripheral)

- | | |
|---|------------|
| ☐ R ☐ L | SHOULDER |
| ☐ R ☐ L | ELBOW |
| ☐ R ☐ L | WRIST/HAND |
| ☐ R ☐ L | HIP |
| ☐ R ☐ L | KNEE |
| ☐ R ☐ L | ANKLE/FOOT |

REFERRER INFORMATION

Name: _____ Prac ID: _____
 Address: _____
 Phone: _____ Fax: _____

STAMP (IF APPLICABLE)

Why Physicians Refer to MSKrehab

FCAMPT Advanced Clinical Reasoning | One-on-one physiotherapy | Evidence-based Rehabilitation | Motor vehicle collision rehabilitation
 Concussion Rehabilitation | TMJ Physiotherapy | Chronic Pain Management | Sports injuries | Progress reports available upon request