BaseLine Concussion Intake

Office Use Only
MB ____ Ref. ____
Rel. ____ FV ____
IFS ____ Wel. ____
Update

Today's Date:_____ **Confidential Patient Information**

Personal Information:

Athlete Name: _____Sex: _M / F_ D.O.B: ____DD__/____MM__/____YYYY__ Age: _____
Home Address: _____ City: _____
Postal Code: _____ Home Phone: _____ School: _____
Email Address: _____ Who's Email is provided: _____
Primary Sport: _____ Organization: _____ Team: _____
League: _____ Calibre: (Rep/House/A/AA/AAA, etc.) _____
Primary Position: _____ Secondary Position: _____
Secondary Sport(s) & Organizations: _____
Have you ever had a concussion? Y N If so, how many? _____ When was the most recent? _____
How long did it take you to fully recover? _____ Are you still experiencing symptoms? _____
Do you have any medical conditions? _____
Do you currently take any medications on a regular basis? _____
Have you ever been diagnosed with ADD, ADHD, or a Learning Disability of any kind? Y N If so, which? _____

Parent/Guardian Information:

	Parent/Guardian #1	Parent/Guardian #2
Parent/Guardian Name(s)		
Parent/Guardian Work Phone		
Parent/Guardian Cell Phone		
Parent/Guardian Email		

OPTIONAL INFORMATION: *We can submit Electronically on your behalf – Please note there are some restrictions for submission*

Extended Health Company Name: _____
Policy Holder's Name: _____ DOB: ____DD__/____MM__/____YYYY
Group No: _____ Certificate/Identification No.: _____
Secondary Coverage Company: _____ Group No: _____ ID#: _____
Secondary Policy Holder's Name: _____ DOB : ____DD__/____MM__/____YYYY

Office Use*: If info filled in- we REQUIRE – a copy of insurance card & Policy Holder needs to sign Electronic Transmission Auth & Consent Form.* ☐

Physician:

Name: _____ Permission to contact? Yes No (circle) Initial: _____
Telephone #: _____ Fax: _____
Address: _____
_____
Email: _____

** Complete Concussion Management is dedicated to furthering the knowledge base surrounding concussion injuries through ongoing research. Please be advised that with your permission, all baseline and post-injury information may be used for research purposes. All personal identifying information will be withheld and kept strictly confidential in accordance with research regulations and the privacy act **

Athlete/Parent Signature of Permission: _____

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Canada Anti-Spam Legislation (CASL)

Under the Canada Anti-Spam Legislation (CASL), effective as of July 1, 2014, we require your consent in order to send you electronic communications; for example, the latest in exercises, nutrition information, class schedules, appointment reminders and any other information that may be of interest to you. To allow us to continue providing information that is relevant to you, please take a moment and check the boxes for the information that you would like to receive.

Active Chiropractic would not want you to miss out on any information that is beneficial to you.

First Name: _____

Last Name: _____

Email address: _____

	Appointment Reminders/Confirmation		
	Clinic Newsletter		Massage Therapy
	Chiropractic		Kinesiology - News
	BootCamp		Personal Training
	Yoga		Nutrition Counselling
	Running Clinics		Physiotherapy
	Counselling		Concussion News/Baseline Expiry
	Naturopathic Medicine		
	I do NOT wish to receive ANY emails		

You may withdraw your consent or modify your subscription preferences at any time.

Dated this_____ day of_____, 20_____.

_____ _____

Signature **Name – please print**

_____ _____

Witness **Witness – please print**