GoodPractice
Physiotherapy

# Class Registration Form

Date: _____

Name: _____ Email: _____

Address: _____

City: _____ Postal Code: _____

Telephone: (H) _____ (C) _____ (W) _____

Date of birth: _____ Sex: ☐ Male ☐ Female

Occupation: _____

Referral: ☐ GP ☐ Ortho ☐ Self ☐ Other: _____

Family physician: _____ City: _____

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**Low Back Pain: Treatment and Prevention**

Date of session requested: _____

Have you had any previous treatment for low back pain? _____

If yes, please list: _____

_____

**Women's Health**

Date of session requested: _____

Do you have specific concerns? _____

If yes, please list: _____

_____

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**General Health**

_____ Bladder: ☐ Normal ☐ Abnormal
_____ Infectious skin conditions
_____ Tuberculosis
_____ Hepatitis
_____ HIV

_____ Allergies: Type _____
_____ Cancer
_____ Digestive disorders: Type _____
_____ Epilepsy
_____ Hemophilia
_____ Hypoglycemia
_____ Pins, plates, prosthesis

_____ Chronic cough
_____ Bronchitis
_____ Shortness of breath
_____ Asthma
_____ Ephysema

_____ High blood pressure
_____ Low blood pressure
_____ Congestive heart failure
_____ Heart disease
_____ Heart attack: When? _____
_____ Stroke: When? _____
_____ Pacemaker or similar device

_____ Arthritis
_____ Diabetes
_____ Dizziness
_____ Ear aches
_____ Hernia
_____ Headaches: Type _____
_____ Vision or hearing loss
_____ Loss of sensation

**Women**

_____ Pregnant
_____ Number of children
_____ Painful menstruation
_____ Menopause

Cheques must be payable to "GOOD PRACTICE PHYSIOTHERAPY."
To secure participation, your cheque must be received prior to class date.

Signature: _____