CONFIDENTIAL PATIENT INTAKE FORM – PHYSIOTHERAPY

Last Name: ____________________________________ Date: _________________

First Name: ____

Address: ____

City:____________________________________Postal Code: ____________________

Phone: Home: __________________________Work: _________________________

Cell: ___________________________________

Which is your preferential number to receive messages? H W C

Occupation: ____________________________ Employer: _______________________

Date of Birth: (D) ___(M)____(Y)___________ Age: ____________________________

Name of Medical Doctor ____

Address:_____________________________________Phone:_____________________

Date of Last Physical Exam: ____

Who should we notify in case of emergency?_________________________________

Relationship of person to you ____

How did you learn of this practice? ____

Your personal information is protected at all times, and is only accessible to your practitioner and staff associated with the clinic that are bound by the Privacy Act. Your personal information is collected only for the purpose of understanding your health status/injury/concern so that you can be assessed and treated.

Please indicate understanding of the above privacy policy and with sharing your personal information by signing and dating below:

Signed______________________________________ Date:_______________________

Justine Blainey Wellness Centre

CURRENT CONCERNS

Please share your concerns in order of importance to you:

1) ____

2) ____

3) ____

4) ____

What happened to cause the concern/problem and when?

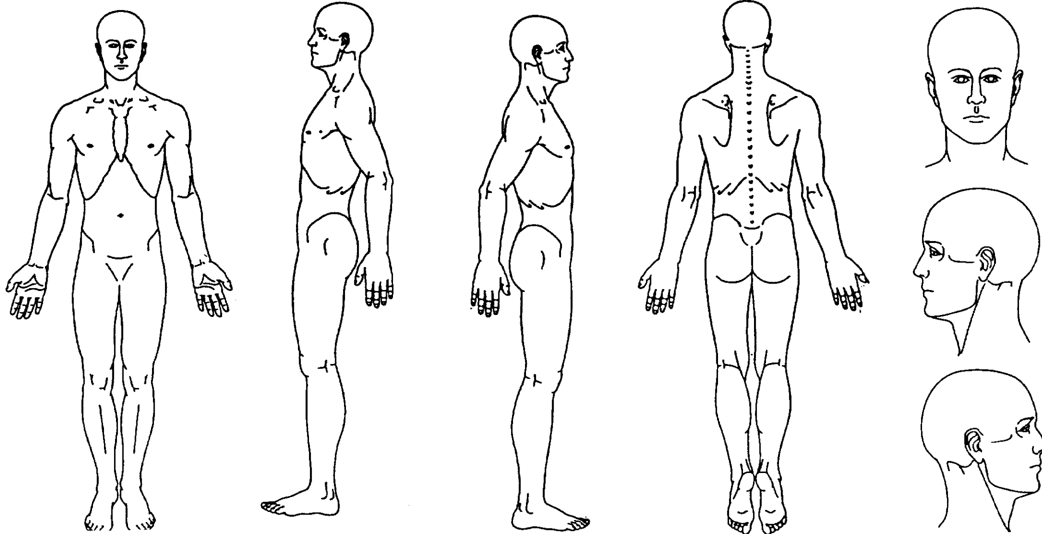
____

____

____

Please indicate the pain location on the diagram and circle the pain description below:

Mark X for painful area(s). Mark arrow for radiation of pain



Aching	Dull	Sharp	Burning
Shooting	Tightness	Tingling	

Pain is (circle what applies)

a) Constant Intermittent
b) Getting better Getting worse
c) Mild Moderate Severe
d) Worse – morning, afternoon, evening, night
e) Relieved by: rest heat movement ice
Medication: (list) ___________________________________
Treatment: (list) ___________________________________
f) Worsened by: rest heat movement ice coughing
Sitting Standing Driving Lifting

PAST MEDICAL HISTORY

Check any relevant statements, place an x by non-applicable statements.

__ This problem is recurrent; list approximate dates of recurrence or frequency in the past ____

__I have had surgery
Date: __________________________ Procedure:____________________________
Date:___________________________Procedure: ____________________________
Date: __________________________ Procedure:____________________________

__ I have had motor vehicle accident(s)
Date: __________________________Residual Problems:______________________
Date: __________________________Residual Problems:______________________

__I have suffered a work injury reported to the Workers' Compensation.
Date: __________________________ Area of injury__________________________

__I have had x-rays taken for this current concern.
Date: __________________________Findings: ______________________________

__I have suffered concussion(s) or been unconscious

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__I am currently taking medication

Please list:____

____

____

____

__ I am taking supplements for my problem or for my general health

Please list:____

____

____

____

Is there anything else you would like to add?

____

____

____

____

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