Physiotherapy & Wellness Centre

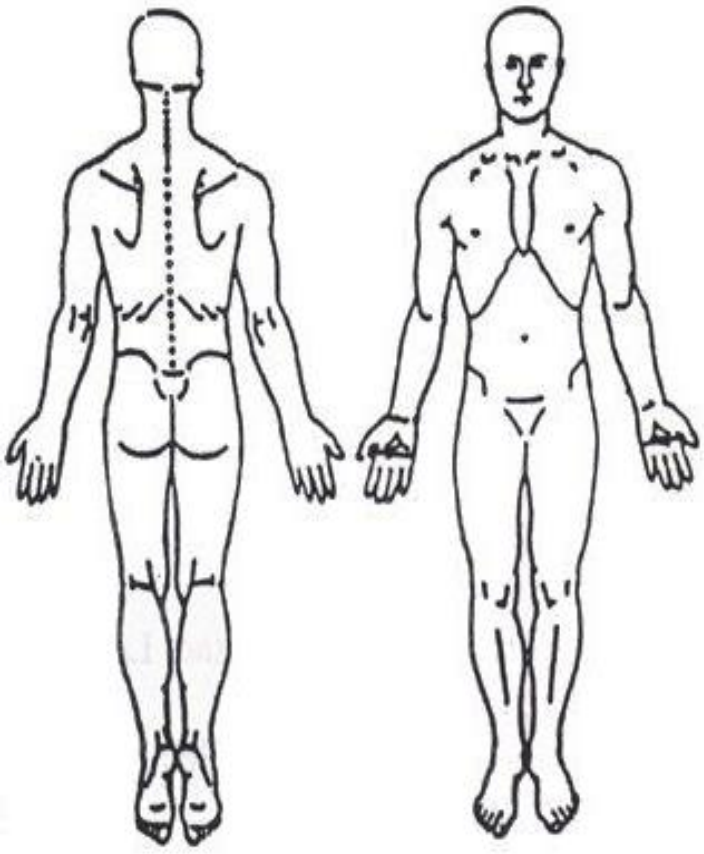
Date: _____

Intake Form

First Name	Last Name	Date of Birth (DD/MM/YY)
Family Doctor	Referring Doctor	Present/Previous Occupation

Have you had previous physiotherapy care? □ Yes □ No
Do you have extended healthcare coverage? □ Yes □ No

Please draw on the diagram where you have your symptoms:



Reason for the appointment:
When did your condition begin:

Have you had any X-rays, MRI or other tests for this current condition:
List any previous surgeries, illnesses, injuries:
List all medications (prescriptions, vitamins, herbal supports, BCP, aspirin, etc.):
List any additional x-rays, MRI, or other tests:
List any hobbies/activities you participate in:
What are your goals for therapy?

Have you ever tested positive for any blood-borne disease? (HIV, AIDS, Hepatitis C, etc.): _____ □ Yes □ No

Are you immunocompromised? □ Yes □ No Are you taking blood thinners? □ Yes □ No

Is this condition related to work? □ Yes □ No Has your employer been notified? □ Yes □ No
Is this condition related to a motor vehicle accident? □ Yes □ No Date of injury: _____

Can you perform your daily home activities? □ Yes □ With help □ Not at all
Can you perform your daily work activities? □ All □ Only some □ Not at all
Describe your stress level? □ None □ Mild □ Moderate □ Severe
Are you, or do you plan to become pregnant? □ Yes □ No □ Unknown
Does your pain affect your sleep? □ Yes □ No
Any recent changes in your bowel or bladder function? □ Yes □ No
Do you have (check all that apply): □ Pins/needles □ Tingling □ numbness: (In the □ arms □ hands □ legs □ feet)

Health History Questionnaire

Have you ever been diagnosed or told you have any of the following?

1. High blood Pressure □ Yes □ No
2. Hardening of the arteries (arteriosclerosis) □ Yes □ No
3. Diabetes □ Yes □ No
4. Tuberculosis □ Yes □ No
5. Cancer, where? _____ □ Yes □ No
6. Heart or blood disease □ Yes □ No
7. Bone spurs on the neck bones (cervical sprain) □ Yes □ No
8. Osteoporosis □ Yes □ No
9. Whiplash injury (flexion-extension injury, cervical sprain) □ Yes □ No
10. Have you ever suffered a stroke? □ Yes □ No
11. Were you ever a smoker? From_____ To_____ □ Yes □ No
12. Do you take any medication on a regular basis? □ Yes □ No
13. Visual disturbances (blurring, loss, double) □ Yes □ No
14. Hearing disturbances (loss, ringing, other noise) □ Yes □ No
15. Slurred speech or other speech problems □ Yes □ No
16. Difficulty swallowing □ Yes □ No
17. Dizziness □ Yes □ No
18. Loss of consciousness, even momentary blackouts □ Yes □ No
19. Sudden collapse without loss of consciousness □ Yes □ No
20. Numbing, loss of sensation, strength or weakness in the face, fingers, hands, arms, legs or any other parts of the body □ Yes □ No