Physiotherapy Intake Form

Name: ____

Date of birth (dd/mm/yyyy): ______________________________ **Occupation:**______________________________

Home phone:___________________________________ **Cell:**____

Address:____

email: ____ **Consent to appointment reminders by email YES/NO**

Emergency contact (name, phone number, relation): ____

Family doctor name/location: ____

Current physical activity (If YES please describe)? YES/NO ____

What is your primary reason for coming in today? ____

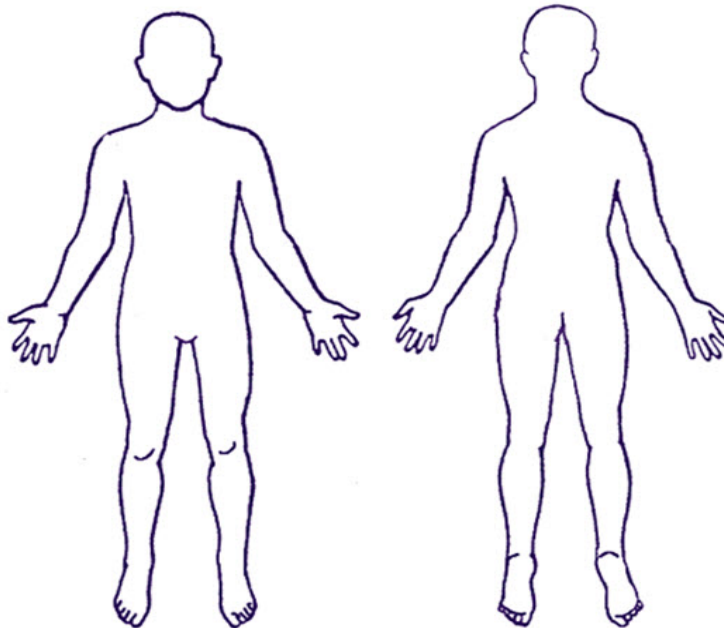
What do you hope to achieve from physiotherapy? ____

On a scale from 0-10 what would you rate your current level of pain? no pain **0 1 2 3 4 5 6 7 8 9 10** extreme pain

When did your pain begin?__________________________ **Is this a new or recurring issue?**___________________

How would you describe your pain? sharp stabbing dull achy burning pins & needles numb other____________

Please shade the affected areas:



Medical History **-** *Please check all that apply*

- ❏ Heart disease/Pacemaker
- ❏ Heart attack
- ❏ Stroke
- ❏ High blood pressure
- ❏ Headaches/Migraines
- ❏ Asthma
- ❏ Previous surgery
- ❏ Metal implant
- ❏ Pregnant
- ❏ Cancer (current or previous)
- ❏ Difficulty swallowing
- ❏ Difficulty speaking
- ❏ Vision difficulties
- ❏ Unexplained weight loss or gain
- ❏ Allergies/Skin sensitivities (please specify)
- ❏ Diabetes
- ❏ Poor circulation
- ❏ Decreased sensation
- ❏ Neuropathy
- ❏ Reynaud's
- ❏ Smoke (current or previous)
- ❏ Osteoporosis
- ❏ Arthritis
- ❏ Fibromyalgia
- ❏ Concussions
- ❏ Dizziness
- ❏ Fainting/blackouts
- ❏ Hemophilia
- ❏ Epilepsy
- ❏ Scoliosis
- ❏ Bowel or bladder difficulties
- ❏ Infectious conditions
  - ❏ HIV, TB, Hepatitis
- ❏ Other ___________________________

Please list any previous surgeries or injuries (please include approximate dates):

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Please list any current medications:

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Privacy - Personal Health Information

Personal information is confidential. It is important for the physiotherapist to know your full health history in order to provide safe and effective treatment.

By signing below I give my consent to undergo physiotherapy assessment and treatment with a registered physiotherapist and that the above information is correct and accurate to the best of my knowledge.

Signature: ____ Date: __________________

I give my consent for my personal health information to be shared with my family doctor or other healthcare professionals ________.