care CLINIC

Physiotherapy/Massage Intake Form

Name: _____

Date of birth (dd/mm/yyyy): _____ Occupation: _____

Home Phone: _____ Cell: _____

Address: _____

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

Family doctor name/location: _____

Referral source (doctor, friend, website): _____

Current physical activity (IF YES please describe)? YES/NO _____

What is your primary reason for coming in today? _____

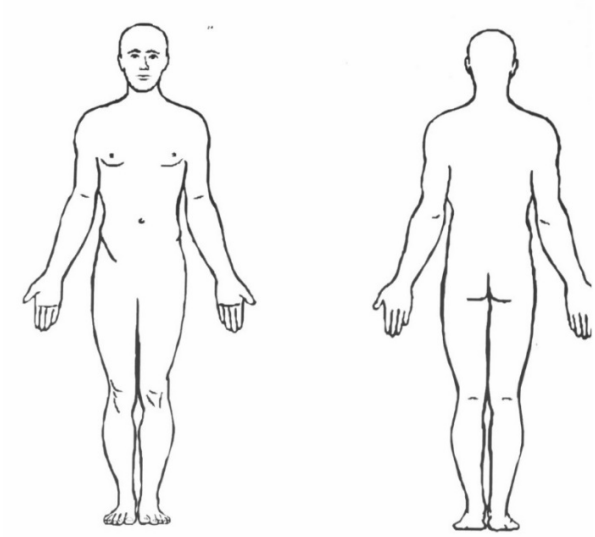
What do you hope to achieve from physiotherapy/massage? _____

On a scale from 1-10, 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:



See Reverse →

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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 □ Raynaud'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:

_____

_____

Please list any medications:

_____

_____

Privacy – Personal Health Information

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

By signing below, I give my consent to undergo physiotherapy/massage therapy assessment and treatment with a registered physiotherapist/registered massage therapist 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 _____.

Date of initial Health History
_____
Update 1: _____
Update 2: _____
Update 3: _____
Update 4: _____
Update 5: _____

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