PEAK HEALTH & PERFORMANCE

Physiotherapy Intake Form

Patient Information 1/10

Date: . . . . . (DD/MM/YYYY) **Full Name:** . . . . . **Preferred Name:** . . . . .

Sex: ☐ Male ☐ Female **Birthdate:** . . . . . (DD/MM/YYYY) **Age:** . . . . . **Marital Status:** . . . . .

Alberta Health Care #: . . . . . **Street Address:** . . . . .

Cell#: . . . . . **Postal Code:** . . . . . **City:** . . . . . **Prov:** . . . . .

Home #: . . . . . **Email:** . . . . .

Occupation: . . . . . **Employer:** . . . . .

Emergency Contact: . . . . . **Relationship:** . . . . . **Phone #:** . . . . .

** We communicate appointment reminders, invoices, receipts, exercise programs & health tips via email. We hate spam, but we really value educational information. Do we have permission to utilize your email address ?* ☐ *Yes* ☐ *No*

Medical Information 2/10

Family Medical Doctor's Name: . . . . . **Clinic:** . . . . .

Date of last MD visit: . . . . . **Reason:** . . . . .

Date of last physical examination: . . . . .

What therapies have you previously received? ☐ Chiropractic ☐ Massage ☐ Acupuncture ☐ Physiotherapy

** Communication between healthcare providers can greatly improve the quality and safety of patient care. If necessary, do you consent to allow your health provider at PHP to contact your medical doctor?* ☐ *Yes* ☐ *No*

Extended Health Benefits & Other Insurance 3/10

Do you have a private insurance plan? ☐ No ☐ Yes (Self) ☐ Yes (Spouse) ☐ Yes (Parent)

Name of primary policy holder (Spouse/Parent): . . . . .

Policy #: . . . . . **Which Company?** ☐ Alberta Blue Cross (ABC) ☐ SunLife

Member ID: . . . . . **Group #:** (ABC Only) . . . . . ☐ Great West Life ☐ Green Shield ☐ Standard Life

Is this a Workman's Compensation Case (WCB)? ☐ No ☐ Yes ☐ SSQ Financial ☐ Chamber of Commerce ☐ Desjardins

Date of Accident: . . . . . ☐ Cowan ☐ Industrial Alliance ☐ Johnson

Is this a Motor Vehicle Accident Case (MVA)? ☐ No ☐ Yes ☐ Manulife ☐ Other: . . . . .

Date of Accident: . . . . .

How Did You Hear About Us? 4/10

☐ Referred by Friend/Family ☐ Referred by Medical Doctor ☐ Internet/Website ☐ Street Sign

☐ Referred by Trainer ☐ Walk In ☐ Health Care Event ☐ Other: . . . . .

*Whom may we thank for this referral? . . . . .

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Current Health Condition &/Or Injury

5/10

Primary Complaint: . . . . . **When did this begin?** . . . . . .

Have you had this before? ☐ No ☐ Yes; When: . . . . . **Is it getting:** ☐ Worse ☐ Better ☐ Not Changing

What is the character of the pain? ☐ Dull & Achy ☐ Numb ☐ Stiff & Tight ☐ Pins & Needles ☐ Sharp ☐ Burning

Is the Condition: ☐ Work-Related ☐ Auto-Related ☐ Fall ☐ Sports-Related ☐ Other: . . . . . .

Please rate your pain: **(LEAST)** 0 1 2 3 4 5 6 7 8 9 10 **(WORST)**

When do you feel the pain? ☐ Constantly ☐ Intermittently ☐ Only at Night ☐ Only in the Morning

Does the pain radiate down your legs or arms? ☐ No ☐ Yes; Describe: . . . . . .

Have you seen anyone else for this condition? ☐ No ☐ Yes; Who: . . . . . .

Have you had any imaging for this condition: ☐ X-Ray ☐ CT ☐ MRI ☐ Ultrasound Date: . . . . . .

What aggravates your pain? ☐ Sitting ☐ Standing ☐ Rest ☐ Bending ☐ Lifting ☐ Exercise ☐ Weather Changes

What relieves your pain? ☐ Rest ☐ Movement ☐ Heat ☐ Ice ☐ Massage ☐ Medication: . . . . . .

Does this problem interfere with: ☐ Work ☐ Family & Social Life ☐ Sports & Hobbies ☐ Sleep

What is your commitment to correcting this problem: 0 1 2 3 4 5 6 7 8 9 10

Do you have any secondary complaints? . . . . . .

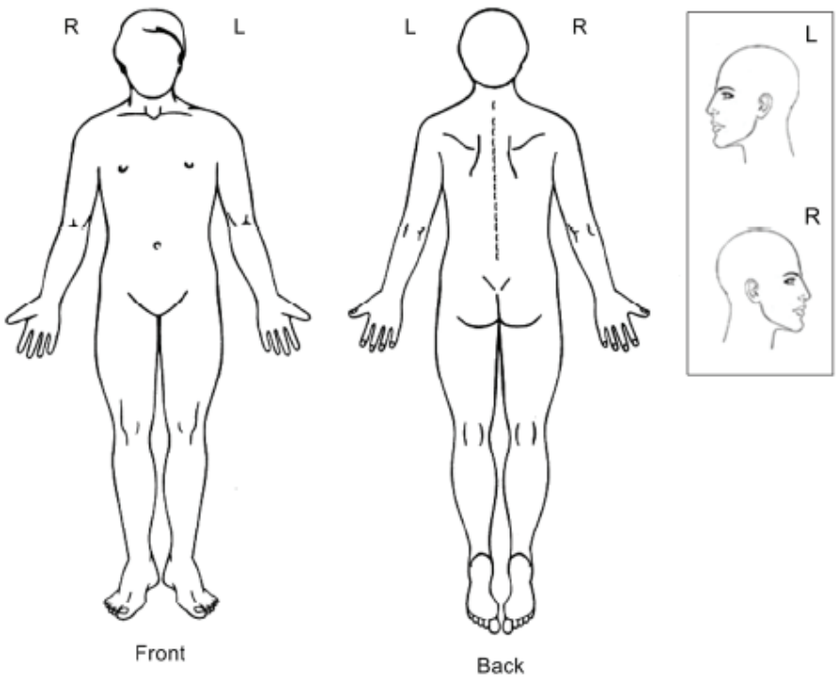
. . . . . .

Symptom Diagram

6/10

Please use the symbols below to mark all of the areas on the diagram that BEST represent the pain and sensations that you are CURRENTLY experiencing:

Numbness	====	Pins/Needles	~~~~	Burning	oooo
Sharp	xxxx	Dull/Achy	ΔΔΔΔ	Stiff/Tight	2222



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Health History 7/10

Have You Ever Had...

Fracture: ☐ No ☐ Yes; where/ when: . . . . . **High Blood Pressure:** ☐ No ☐ Yes; when: . . . . . .

Major Surgery: ☐ No ☐ Yes; where/when: . . . . . **High Cholesterol:** ☐ No ☐ Yes; when: . . . . . .

Car Accident: ☐ No ☐ Yes; when: . . . . . **Are you pregnant?** ☐ No ☐ Yes; Due Date: . . . . . .

A Concussion: ☐ No ☐ Yes; when/ how: . . . . . **# of Past Pregnancies:** . . . . . **# of Children:** . . . . . .

Been Hospitalized: ☐ No ☐ Yes; when/why: . . . . . .

Been Diagnosed With: ☐ Cancer ☐ HIV/AIDS ☐ Hepatitis A/B/C ☐ Other: . . . . . When: . . . . . .

Do you have any allergies: ☐ No ☐ Yes; List: . . . . . .

Please list any medications/supplements that you are *currently* taking: . . . . . .

. . . . . .

Family History 8/10

Is there a family history of:	Heart Disease	Stroke	Cancer	Diabetes	Arthritis	Other
***Mother's Side:**	☐	☐	☐	☐	☐	. . . . .
***Father's Side:**	☐	☐	☐	☐	☐	. . . . .

Lifestyle 9/10

Are you currently a smoker? ☐ No ☐ Yes; amount: . . . . . **Did you smoke previously?** ☐ No ☐ Yes; when: . . . . . .

Do you exercise regularly? ☐ No ☐ Yes; type & frequency: . . . . . .

Do you consume alcohol? ☐ No ☐ Yes; amount/frequency: . . . . . **Coffee?** ☐ No ☐ Yes; amount: . . . . . .

Do you have a healthy & balanced diet? ☐ No ☐ Don't Know ☐ Yes, I think so ☐ Yes, definitely

What are your stress levels? ☐ Extreme ☐ High ☐ Moderate ☐ Low ☐ Very Minimal

Health Status Survey 10/10

Please check the box of any conditions or symptoms that you have had in the past *six months*:

General:
- ☐ Fever
- ☐ Fainting
- ☐ Night Pain
- ☐ Headaches
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Anxiety/Nervous
- ☐ Excessive Sweating

Neurological:
- ☐ Dizziness
- ☐ Paralysis
- ☐ Nausea
- ☐ Convulsions
- ☐ Clumsiness
- ☐ Blurred Vision
- ☐ Loss of Balance
- ☐ Numbness/Tingling

Cardiovascular:
- ☐ Angina
- ☐ Chest Pain
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Poor Circulation
- ☐ Previous Stroke
- ☐ Irregular Heartbeat
- ☐ Previous Heart Attack

Respiratory:
- ☐ Asthma
- ☐ Sore Throat
- ☐ Frequent Colds
- ☐ Chronic Cough
- ☐ Sinus Infections
- ☐ Spitting up Blood
- ☐ Spitting up Phlegm
- ☐ Difficulty Breathing

Genitourinary:
- ☐ Kidney Infection
- ☐ Menopause
- ☐ Painful Breasts
- ☐ Prostate Trouble
- ☐ Trouble Urinating
- ☐ Blood in Urine/Stool
- ☐ Painful Menstruation
- ☐ Irregular/Absent Cycle

Eyes/Ears/Nose/Throat:
- ☐ Eye Pain
- ☐ Ringing in Ears
- ☐ Worsening Vision
- ☐ Earaches/Infection
- ☐ Hearing Difficulty

Muscle & Joint:
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Elbow Pain
- ☐ Shoulder/Arm Pain
- ☐ Knee/Leg Pain
- ☐ Hip/Groin Pain
- ☐ Wrist/Hand Pain
- ☐ TMJ/Jaw Pain
- ☐ Fibromyalgia
- ☐ Arthritis
- ☐ Disc Herniation
- ☐ Sciatica
- ☐ Ankle/Foot Pain
- ☐ Gout

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