



Youth (6-12 Years) Physiotherapy Intake Form

Patient Information 1/9

Date: DD/MM/YYYY Child's Name: Preferred Name:

Sex: Male Female Birthdate: DD/MM/YYYY Age: School Grade Level:

Alberta Health Care #: Street Address:

Mother's Name: Postal Code: City: Prov.:

Father's Name: Email:

Home #: Work #: Cell #:

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 2/9

Family Medical Doctor's Name: Clinic:

Date of last MD visit: Reason:

Date of last physical examination:

What therapies has your child 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 child's medical doctor? Yes No*

Extended Health Benefits & Other Insurance 3/9

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? 4/9

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?*

Health History

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Primary Complaint/Purpose of Appointment:

When did this begin?

Has your child had this before? No Yes; When: Is it getting: Worse Better Not Changing

Is the Condition: Auto-Related Sports-Related Fall Other:

Has your child seen anyone else for this condition? No Yes; Who:

Has your child had any imaging for this condition: X-Ray CT MRI Ultrasound Date:

Is your child presently taking any medications/supplements?

Are there any secondary complaints/conditions?

General Health History

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Any Known Health Conditions/Illnesses? No Yes; List:

Childhood Diseases? Mumps Measles Chicken Pox Small Pox Diabetes Pneumonia Asthma

Big Falls or Injuries? No Yes; List:

Hospitalizations/Surgeries? No Yes; List:

Fractures? No Yes; Where/When:

Any Allergies? No Yes; List:

Vaccination History:

Family History

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Is there a family history of: Heart Disease Stroke Cancer Diabetes Arthritis Other

*Mother's Side:

*Father's Side:

Lifestyle

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Does your child participate in sports/exercise regularly? No Yes; type/frequency:

Does your child have a healthy & balanced diet? No Don't Know Yes, I think so Yes, definitely

What are your child's daily stress levels? Extreme High Moderate Low Very Minimal

What is your child's quality of sleep? Excellent Fair Poor; Hours/night:

Health Status Survey

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Please check the box of any conditions or symptoms that your child has had in the past six months:

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> Sore Muscles | <input type="checkbox"/> Arm Pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Seizures | <input type="checkbox"/> Spinal Curvature |
| <input type="checkbox"/> Sore Joints | <input type="checkbox"/> Walking Problems | <input type="checkbox"/> Loss of Weight | <input type="checkbox"/> Earaches/Infections | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Growing Pains | <input type="checkbox"/> Feet Turn In/Out | <input type="checkbox"/> Poor/Excessive Appetite | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Coordination Problems | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Stomach Aches | <input type="checkbox"/> Bed wetting |
| <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Clumsiness | <input type="checkbox"/> Depression/Confusion | <input type="checkbox"/> Diarrhea | |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Eczema | |
| <input type="checkbox"/> Pain b/w Shoulders | <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Slow Weight Gain | |