Physiotherapy Intake Form

Welcome to our clinic. Please complete the following questionnaire to assist in determining if chiropractic care can help you. If we do not believe your condition will respond satisfactorily, we will refer you to the appropriate healthcare provider in a timely manner.

PERSONAL INFORMATION Date _____

Name: _____ / _____ / _____ ❑ Male ❑ Female
Last First Middle Initial

Personal Health #: _____ - _____ Birth Date: _____ /_____ /_____
YYYY MM DD

Height: _____ Weight: _____ Marital Status: ❑ M ❑ S ❑ W ❑ D

Home Address: _____ City: _____ Postal Code: _____

Current Occupation: _____

Phone #'s: Home _____ Cell _____ Bus _____

Do you consent to receiving emails regarding health information, reminders, and important clinic updates?
❑ Yes, I consent to receiving email communication from the clinic.

Email Address: _____

Family Doctor (G.P.): _____
Name Location Phone Number

Please be advised that in the interest of inter-professional communication, we will be in touch with your physician regarding the care you receive at our clinic.

Emergency Contact: _____
Name Relationship Phone Number

How did you hear about us?
❑ Google ❑ Facebook ❑ Instagram ❑Twitter ❑ TV ❑ Radio ❑ Referred by: _____

Is this a workplace injury? ❑ Yes ❑ No *Please be advised that we do not accept WCB cases.

Is your injury the result of a motor vehicle accident? ❑ Yes ❑ No If yes, additional intake forms are required.

The healthcare team in this clinic meets regularly to discuss interdisciplinary co-treatment of our patients. If you **do not** wish us to discuss your case, please initial here: _____

Our clinic is committed to evidence-based practice and contributing to the scientific research community. All patient information used in research is kept strictly confidential and is used only with permission of the patient. Do you consent to allow your information to be used in future research? ❑ Yes ❑ No

Missed office Visits:
A charge of $80 will be made in the event of a missed office visit, or if less than 24 hours' notice is given when canceling an appointment.

Attire / Hygiene:
Some treatments necessitate direct skin contact. Please bring shorts and / or a tank-top style shirt to each appointment and bathe before attending your appointment.

HEALTH INFORMATION

1. Was there an incident that brought on your current problem/injury?

   ❑ Yes. Please describe _____

   ❑ No

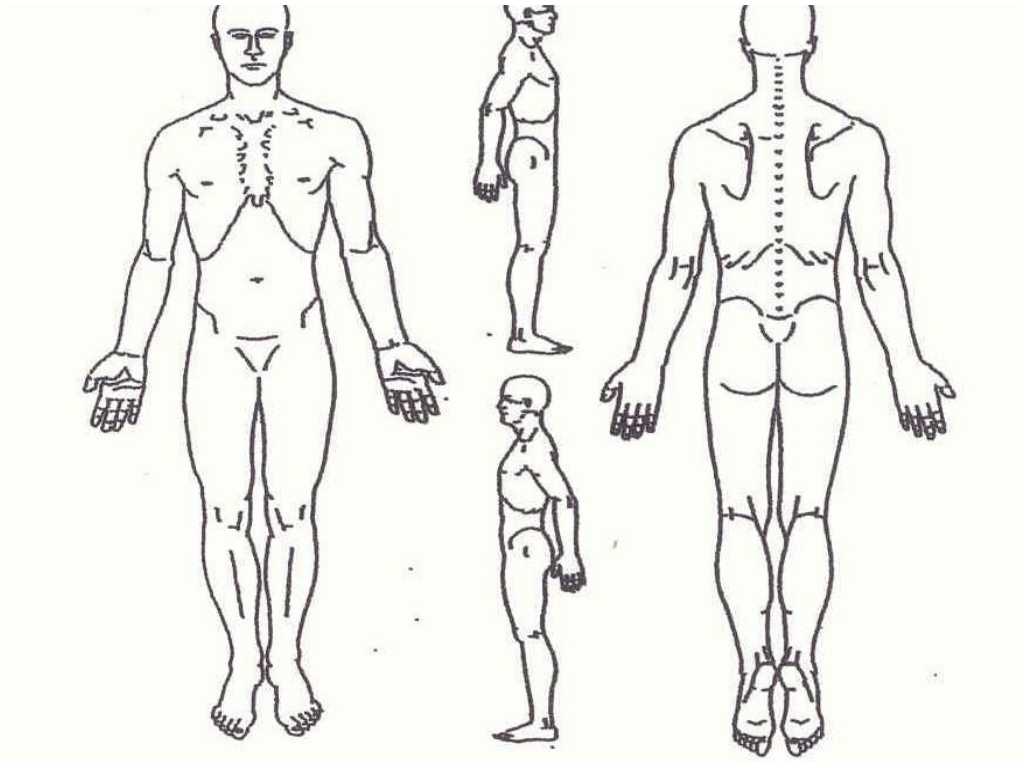
2. How long have you been experiencing this problem for? _____

3. Using the line scale provided below, rate your level of pain over the **last 24 hours**.

   No Pain 0=====1=====2=====3=====4=====5=====6=====7=====8=====9=====10 Severe Pain

4. Mark the areas on the body drawings where you feel the following sensations using their corresponding symbols

Sensation:	Ache	Numbness	Pin & Needles	Burning	Stabbing
	\\\\\\\\	++++++	oooooo	bbbbb	ssssss



5. Is your pain: ❑ off and on *or* ❑ constant, 24 hours a day

6. Is your pain: ❑ getting better *or* ❑ getting worse *or* ❑ staying the same

7. What makes your pain **worse**? _____

8. What makes your pain **better**? _____

9. At what time of day does it seem to be at its worst? _____

10. Do you currently or have you in the past experienced any of the following conditions or symptoms related to your injury?

- ❑ Dizziness
- ❑ Balance Problems
- ❑ Change in bladder or bowel function
- ❑ Numbness in the face
- ❑ Numbness in the groin region
- ❑ Pain when coughing or sneezing

11. Describe anything at work or any daily activities that affect your injury/pain levels (eg. Prolonged sitting, physical demands, stress)

_____

_____

12. Are there any sports, activities or hobbies that you enjoy doing?

_____

_____

PHYSICAL HISTORY

13. If you have been treated for any of the following conditions please indicate with a check mark:

MUSCULOSKELETAL
- ❑ Fracture, where? _____
- ❑ Sprain/Strain
- ❑ Joint Replacement
- ❑ Whiplash
- ❑ Gout, where? _____
- ❑ Arthritis (OA, RA)

SKIN
- ❑ Eczema/Dermititis
- ❑ Psoriasis
- ❑ Fungal Infection
- ❑ Other _____

NERVOUS SYSTEM
- ❑ Fainting/Dizziness
- ❑ Seizures/Epilepsy
- ❑ Neurological Disorder

GASTROINTESTINAL SYSTEM
- ❑ Hemorrhoids
- ❑ Abdominal Pain
- ❑ Digestive Problems
- ❑ IBS

CARDIOVASCULAR SYSTEM
- ❑ Heart Disease
- ❑ Blood Pressure
  High / Low
- ❑ Blood Clots
- ❑ Circulatory Issues
- ❑ Varicose Veins

RESPIRATORY SYSTEM
- ❑ Emphysema
- ❑ Bronchitis
- ❑ Asthma
- ❑ Pneumonia

OTHER
- ❑ Kidney Disorder
- ❑ Liver Disorder
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Diabetes
  Type I / Type II
- ❑ Cancer
- ❑ Anemia
- ❑ Hemophilia
- ❑ HIV/AIDS
- ❑ Hepatitis
- ❑ Headaches/Migraines
- ❑ Depression
- ❑ Anxiety

14. Do you have any other information that would be beneficial to <u>YOUR</u> treatment?

_____

_____

_____

The information that I have provided is accurate to the best of my knowledge. I understand that due to the nature of the treatment I am REQUIRED to notify the therapist and my family physician of any contagious and/or communicable diseases.

Name (Print): _____ Signature: _____ Date: _____

INFORMED CONSENT TO TREATMENT

Physiotherapy involves many different types of physical evaluation and treatment. As with all forms of medical treatment, there are benefits and risks involved. Physiotherapy treatment techniques may include but are not limited to: manual techniques, electrotherapeutic modalities, acupuncture, intramuscular stimulation (IMS), joint manipulations and exercise. There is no guarantee that the treatment will help the condition you are seeking treatment for and there is a risk that the treatment will cause some discomfort or aggravation of the existing condition.

The physiotherapist will only provide treatment they deem appropriate and that they are qualified to provide. Physiotherapy treatment is the most effective when you participate according to the treatment plan agreed upon with the therapist.

I, _____, consent to the rendering of physiotherapy evaluation and treatment at Elite Sport Performance/The Knee Clinic. I understand it is my responsibility to inform the physiotherapist of any discomfort or pain I may experience during treatment. I also understand that I have the right to decline treatment at any time.

Patient Signature: _____ Date: _____