Physiotherapy Intake Form

For Cheri Walsh BSc(Bio), BSc(PT)

Name: ______________________________________ Date: _____________________________

Mailing Address: ____

____

Date of Birth: ___________________________ Gender: F M Age: _____________

Marital Status: ____________ Partner's name: _______________________________________

Phone #: (h)____________________ (w)____________________ (c) _____________________

E-Mail address: ____

Occupation: _______________________________ # of hours worked per week: ____________

Recreational activities/hobbies: ____

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Main complaint: ____

How long have you had this problem? ____

Other health concerns: ____

____

Family Doctor: ____

How did you hear about Pillars of Health? ____

Do you consult with other health care providers (or have you in the past)? (Circle all that apply)

Naturopath Chiropractor Massage Therapist Physiotherapist Acupuncturist

Homeopath Osteopath Nutritionist/Dietitian

Most insurance companies cover physiotherapy services but you should check your plan to determine the amount of coverage you have per year **and per treatment**, as well as other terms of your reimbursement. Direct billing is available for most insurance plans. Please ask reception for more information and provide them with details of your insurance plan if you wish to direct bill.

Missed appointment and cancellation policy

We require 24 hours notice to cancel an appointment as we have reserved that time for you and others may be waiting for an appointment. If you miss an appointment without adequate notice you will be charged half the cost of the appointment. Please note that you will be billed directly as cancellations and failing to attend are not covered by your health plan.

Consent to communicate and comply

I give consent for Cheri Walsh BSc(Bio) BSc(PT) to communicate with and send reports to the following professionals:

____
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____

I have read the understand all information on this form and agree to adhere to the conditions therein.

Patient's signature: ____

Date: ____

Consent to Assessment and Treatment

I _________________________________give my consent to be assessed and treated by Cheri Walsh BSc(Bio) BSc(PT). I understand that I may stop the assessment and treatment at any time and I may ask questions about the assessment and treatment at any time.

Patient's signature: ____

Date: ____

Health History Inventory

Name: ____ Date: ________________________________

Mark a "**C**" beside your current conditions/issues and a "**P**" for past conditions/issues. Circle conditions or body parts to be more specific if you wish.

Head/Ear/Nose/Throat	**Musculoskeletal**	**Respiratory** (lungs)
Tension Headaches Migraine Headaches Other Headaches Concussion or head trauma Jaw Pain or clicking Hearing impairment Tinnitus (ringing in ears) Sinus congestion/infections Teeth grinding or clenching Dizziness Visual impairment	Low back pain Mid back pain Neck pain Arthritis Tendonitis Bursitis Bone fracture Pain in shoulders, elbows, wrists or hands Pain in hips, knees, ankles or feet	Shortness of breath Asthma Emphysema Bronchitis Tuberculosis Pneumonia Frequent colds/flu Chronic cough Smoker Breathing allergies
Digestive	**Genitourinary**	**Cardiovascular** (Heart)
Liver disease Heartburn/Indigestion/Reflux Diarrhea or loose stools Constipation or dry stools Gall bladder disorder or stones Irritable bowel syndrome Colitis/Chrones/Celiac disease Hernia Nausea	Urinary/bladder disorder Kidney disorder or stones PMS Painful or irregular periods Heavy flow Menopausal (or pre/post)	Coronary/Artery disease Heart attack/chest pain Stroke/Aneurism Pacemaker High/Low blood pressure Varicose veins High cholesterol Heart palpitations Swelling in legs/ankles/feet Hemorrhoids Hemophilia
Endocrine (hormones)	**Psychological**	**Dermatology** (skin)
Thyroid disorder Diabetes Menopause symptoms Night sweats Insomnia or poor sleep Hours of sleep per night ________ Eating habits (poor/fair/good) Exercise (____ x per week) Other__________________________	Attention deficit disorder Panic, anxiety or phobias Depression or bipolar disorder Difficulty making decisions Poor memory Mental confusion Bored or uninterested in things Thoughts of killing yourself Substance abuse Other__________________________	Dermatitis, Eczema or Hives Skin allergies Dry skin Psoriasis Other___________________ _________

Neurological (nerves and brain)	**Cancer** (please elaborate)	**Other**
Multiple Sclerosis Polio Epilepsy or seizures Muscle tremors or tics Sciatica Carpal tunnel syndrome Radiating pain Tingling Numbness Paralysis Other_________________________	**Surgeries** (please elaborate)	Anorexia or bulimia Chronic Fatigue Syndrome Mononucleosis Fibromyalgia Autoimmune disorder Lethargy, lassitude or tiredness Aids or HIV Shingles Overstressed

Use this space to elaborate on any of the above health issues and/or document on any health issues you have that were missed in the check list.

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