



Physiotherapy Intake Form
Carolyn Roosen, Physiotherapist

Name: _____
Date of Birth (DD/MM/YYYY): _____
Phone: _____ / Email: _____
Occupation: _____
Family physician: _____

Concurrent treatments: chiropractic massage naturopathy osteopathy

Main Complaint: _____
Type: Acute injury Chronic complaint Post-op Pre-op MVA
How did it happen? _____
Date symptoms started: _____
Date visited physician? _____
Treatment received _____
Have you had diagnostic imaging? X-ray CT scan MRI None
Date and results (if applicable): _____

Do you have a health history of any of the following? Please check all that apply.

<input type="checkbox"/> Diabetes	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Asthma
<input type="checkbox"/> Cardiac disease	<input type="checkbox"/> Blood clots	<input type="checkbox"/> Stroke
<input type="checkbox"/> Liver or kidney disease	<input type="checkbox"/> Lung disease	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Cancer	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Migraines
<input type="checkbox"/> Anxiety and/or depression	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Smoker _____ ppd	<input type="checkbox"/> Metallic implants (pins, etc.)	<input type="checkbox"/> Currently pregnant
<input type="checkbox"/> Other: _____		

Have you also recently experienced?

double vision or dizziness difficulty with speech/swallowing ringing in the ears
 changes in bowel/bladder function frequent headaches changes in appetite or weight

Current medications (include aspirin, vitamins, minerals, prescription and non-prescription):

Please list previous surgeries and severe injuries:

Physical Activity (frequency and type):

On a scale of 0 (least) to 10 (most severe), what is your pain:

Now:	0	1	2	3	4	5	6	7	8	9	10
Worst:	0	1	2	3	4	5	6	7	8	9	10
Best:	0	1	2	3	4	5	6	7	8	9	10

What makes your pain worse? _____

What makes your pain better? _____

Your pain is (circle all that apply): aching burning numbness tingling sharp dull radiating

Does your pain wake you up at night? yes no

Does your current condition interfere with daily tasks exercise routine work

What are your goals for physiotherapy? _____

Physiotherapy Consent Form

PLEASE READ CAREFULLY AND THOROUGHLY, AND INITIAL EACH SECTION

Informed Consent:

- I understand that I need to express all of my health concerns (both current and past) to my therapist, including any contagious or infectious condition that I might have.
- I consent to an examination and treatment performed by a licensed physiotherapist. The results will then assist the physiotherapist in determining the appropriate physical treatment to meet my specific needs and goals.
- I understand that my treatment with the physiotherapist may involve the use of stretching, mobilization of joints and tissues, and exercise programs aimed at mobility, strength and function
- I understand that discomfort may occur following treatment. The therapist will contact my physician should the presence of symptoms represent any potential risks. I understand that it is my responsibility to contact my therapist should I experience any unusual symptoms.
- I understand that if at any time I am not comfortable with, and/or do not understand the purpose of any treatment procedure I will ask the physiotherapist for further explanation/information. I understand that I may stop the assessment or treatment procedure at any time.

I have read, understood, and had the opportunity to discuss the Informed Consent form. **Initial:** _____

We collect, use, and disclose health information according to the Personal Health Information Privacy Act.

I agree to Pillars of Health collecting, using and disclosing my health information to: **Initial:** _____

- other health practitioners of Pillars of Health
- my family physician or referring doctor
- my insurer, as required

READ AND INITIAL THE FOLLOWING

Initial: _____

- Payment or co-payment is required at time of service.
- If your claim is denied, you are responsible for payment.
- If you do not provide more than 24 hours notice to cancel or reschedule an appointment, a no-show

My signature below indicates my understanding of all of the above information.

Signature of Patient

Date: _____

Signature of Parent or Guardian

Print name of Parent or Guardian