Physiotherapy Intake Form
Carolyn Roosen, Physiotherapist

Preferred Pronoun (he/him, she/her, they/them, etc.): ___________________________
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.

[ ] Diabetes
[ ] Cardiac disease
[ ] Liver or kidney disease
[ ] Cancer
[ ] Anxiety and/or depression
[ ] Smoker _________ ppd
[ ] High blood pressure
[ ] Blood clots
[ ] Lung disease
[ ] Multiple sclerosis
[ ] Osteoporosis
[ ] Metallic implants (pins, etc.)
[ ] Asthma
[ ] Stroke
[ ] Thyroid disease
[ ] Migraines
[ ] Arthritis
[ ] Currently pregnant
[ ] 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 THROUGHLY, AND INTIAL 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 charge equal to half of the appointment charge will be issued.

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

____ Date: _____________________________________

Signature of Patient

____ ____

Signature of Parent or Guardian *Print name of Parent or Guardian*