

Physiotherapy Intake Form

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

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

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: _____

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:

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.

<p style="text-align: center;">Head/Ear/Nose/Throat</p> <p>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</p>	<p style="text-align: center;">Musculoskeletal</p> <p>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</p>	<p style="text-align: center;">Respiratory (lungs)</p> <p>Shortness of breath Asthma Emphysema Bronchitis Tuberculosis Pneumonia Frequent colds/flu Chronic cough Smoker Breathing allergies</p>
<p style="text-align: center;">Digestive</p> <p>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</p>	<p style="text-align: center;">Genitourinary</p> <p>Urinary/bladder disorder Kidney disorder or stones PMS Painful or irregular periods Heavy flow Menopausal (or pre/post)</p>	<p style="text-align: center;">Cardiovascular (Heart)</p> <p>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</p>
<p style="text-align: center;">Endocrine (hormones)</p> <p>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 _____</p>	<p style="text-align: center;">Psychological</p> <p>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 _____</p>	<p style="text-align: center;">Dermatology (skin)</p> <p>Dermatitis, Eczema or Hives Skin allergies Dry skin Psoriasis Other _____ _____</p>

