PATIENT INTAKE FORM

( ) Extended Health ( ) W.S.I.B. (Workplace Safety & Insurance Board) ( ) Motor Vehicle Accident

Date: _____

First Name: _____ Last Name: _____

Address: _____

City: _____ Postal Code: _____

Home Number: _____ Cell Number: _____

Email address: _____ Would you prefer reminders by: Phone Email

Birth date: (day/month/year): _____ Age: _____

Referring Physician: _____ Occupation: _____

Date of injury: _____ Age of injury (how long): _____

Emergency Contact: _____ Relationship: _____

Phone Number: _____ Referral Source:_____

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* For **Extended Health coverage/Private benefits** please fill out the following section.

Insurance company:_____ Insurer name:_____
Policy number: _____ Member ID/certificate number:_____

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* For therapy covered by **Workplace Safety & Insurance Board (WSIB)** please fill out the following section.

W.S.I.B. Claim Number: _____ Employer Name: _____

Employment Address:_____

Employer's Phone Number:_____ Fax Number: _____

Employment Status: _____ Occupation: _____

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* For therapy covered by **Motor Vehicle Accident (MVA)** please fill out the following section.

Insurance company's name: _____ Policy number:_____
Claim Number: _____ Adjuster's information:_____

310 King Street East, Kitchener, ON, N2G 2L3
Phone:: 226-215-3114, Fax: 226-646-7848, Email: kitchenerphysio@gmail.com

MEDICAL HISTORY FORM

The information requested below will help us in treating you safely. Please note that all information below will be kept confidential unless requested by law. Your written permission will be required to release any information.

Have you received physiotherapy treatment before? Yes No

Cardiovascular

( ) high blood pressure
( ) low blood pressure
( ) chronic congestive heart failure
( ) heart attack
( ) phlebitis/varicose disease
( ) stroke/CVA
( ) pacemaker or similar device
( ) heart disease

Is there a family history or any of the above? Yes / No

Respiratory

( ) chronic cough
( ) shortness of breath
( ) bronchitis
( ) asthma
( ) emphysema

Is there a family history of any of the above? Yes / No

Infections

( ) hepatitis
( ) skin conditions
( ) TB
( ) HIV
( ) herpes

Other Conditions

( ) Constant night pain
( ) loss of sensation, where: _____
( ) diabetes, onset: _____
( ) allergies/hypersensitivity
Please list: _____
( ) Type of reaction: _____
( ) epilepsy
( ) cancer, type: _____
( ) skin conditions
Please list: _____
( ) arthritis
( ) bowel bladder issues
( ) night sweats
( ) sudden weight loss

Head/Neck

( ) history of headaches
( ) history of migraines
( ) vision problems
( ) ear problems
( ) hearing loss

Women

( ) pregnant, due date: _____
( ) gynecological condition
Please list: _____

Overall, how is your general health?
_____
_____

Family Doctors name: **Address:**

Current medications: _____
_____
_____
_____

Conditions medications treat: _____
_____
_____
_____

Please list previous surgeries and the date:
_____
_____

Do you have any other medical conditions? (e.g.. Digestive conditions, hemophilia, osteoporosis, mental illness.) Yes / No
_____

Do you have any internal pins, wires, artificial joints or special equipment: Yes / No
If so, please list: _____
What is the reason you are seeking physiotherapy? Please include the location of any tissue or joint discomfort_____

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