PHYSIOTHERAPY INTAKE FORM

CLIENT INFORMATION:

Name: ______________________ DOB (MM/DD/YYYY): ______________

Address: ____
Street City Postal Code

Email: ______________________________ AHC: ______________

Phone (H): ____________ (W): ____________ (C): ____________

Emergency Contact: ______________________ Phone: ____________

Family Physician: ______________________ Phone: ____________

Referred by: (Circle One) Family / Friend ______________________

Doctor Massage Therapist Physiotherapist

Phone Book Sign Other

HEALTH HISTORY

1. What is your primary complaint (or body part) that you are seeking treatment for today?

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2. Do you presently or have you ever had any of the following? Check all that apply.

- ☐ Pacemaker
- ☐ Heart Problems
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Lung Problems
- ☐ Cancer
- ☐ Diabetes
- ☐ Osteoporosis/Osteopenia
- ☐ High Blood Pressure
- ☐ Currently Pregnant
- ☐ Arthritis
- ☐ HIV / AIDS
- ☐ Chronic Fatigue
- ☐ Repeated Infections
- ☐ Thyroid Problems
- ☐ Skin Disease/Sensitivity
- ☐ Depression
- ☐ Asthma
- ☐ Epilepsy/Seizures
- ☐ Anxiety
- ☐ Viral Hepatitis
- ☐ Liver Disease (Fatty Liver)
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Allergies
- ☐ ADHD
- ☐ Other ______________

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3. Please provide a list of any surgeries, major traumas, or car accidents:

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4. Please provide a list of your current medications:

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Date: ______________________ *Signature:* ______________________