feel better **LK Physio**

Patient Intake Form

Name: _____
Address: _____
City: _____
Province: _____ Postal Code: _____
Phone: _____
Email: _____
Gender: ❑Male ❑Female Age: _____

Occupation: _____
Currently working?: ❑
Work duties: _____
_____
_____
Referred by: _____
Dominant Hand: ❑right ❑left

Medical History

Please indicate if the following apply to you - indicate past or present

Head and Neck

❑ Headaches (frequency)
_____
❑ Migraines (frequency)
_____
❑ Head injury (when)
_____
❑ Concussion (when)
_____
❑ Jaw/TMJ
❑ Whiplash (when)
_____
❑ Vision Changes
❑ Ear Problems
❑ Fainting
❑ Dizziness
❑ Sinus
❑ Facial pain
❑ Stroke
❑ Other Neurological Issues

Cardiovascular

❑ High Blood Pressure
❑ Low Blood Pressure
❑ Chronic Congestive Heart Failure
❑ Heart Attack (date_____)
❑ Stroke (date_____)
❑ Aneurysm (date_____)
❑ Pacemaker

Pelvic

❑ Pelvic Pain
❑ Incontinence (stress?)
❑ Infertility
❑ Painful or Irregular Menses
❑ D & C
❑ C-Section

Birth & Children

❑ Birth Trauma
❑ Feeding Problems
❑ Colic
❑ Recurrent Ear Infections
❑ Developmental Delays
❑ Behavioral
❑ Restlessness
❑ ADD/ADHD
❑ Learning Problems
❑ Eye Motor Problems
❑ PDD/Autism

Other Conditions

❑ Osteoporosis
❑ HIV
❑ TB
❑ Skin Conditions
❑ Hepatitis
❑ Diabetes
❑ Epilepsy/Seizures
❑ Cancer (type & date)
_____
❑ Arthritis
❑ Insomnia
❑ Fatigue
❑ Numbness/tingling (where)
_____
❑ Hyper/Hypothyroid
❑ Surgical removal of organ (which)
_____
❑ Depression
❑ Chronic Alcohol use
❑ Allergies (list)
_____
_____

Respiratory

❑ Chronic Respiratory Condition
❑ Shortness of Breath
❑ Bronchitis
❑ Asthma
❑ Emphysema
❑ Smoker or live with Smoker

Gastrointestinal

❑ Nausea
❑ Constipation
❑ Diarrhea
❑ Hemorrhoids
❑ Ulcer
❑ Irritable Bowel Syndrome
❑ Colitis
❑ UTI/Bladder Infections
❑ Other Urinary Conditions
❑ Heartburn

Physical

❑ Bone Fracture (which & when)
_____
❑ Rods/Pins/Plates (where)
_____
❑ Implants (where)
_____
❑ Transplants (which)
❑ Heartburn
❑ Corrective Lens/Contacts
❑ Spinal Injury
❑ Varicose Veins
❑ Fibromyalgia
❑ Joint Dislocation (which & where)
_____
❑ Unexplained weight loss/gain

Other: _____
_____

Current Health Picture

How would you rate your overall health (1:poor, 5:great).....

Main current health concerns:

How would you rate your overall activity (1:sedentary-I don't move unless I have to, 5: very active).....

What are the major limitations in your activity levels?

What types of activity do you currently do? Frequency?

How would you rate your sleep? (1:poor, 5:great).....

What is your sleeping position? Do you have sleep limitations due to pain?

List all medications and supplements you are currently taking.

List all past surgeries or procedures and dates.

List dates and reasons for previous hospitalizations.

Current Condition

Describe your current condition

How and when did this start?

Is it getting better, worse or staying the same?

Are the symptoms constant or intermittent?

What makes the symptoms better? (ie stretches, hotpacks, medications)

What makes the symptoms worse? (ie certain movements, postures)

Has this problem happened before? If so, what treatment was done, was it successful?

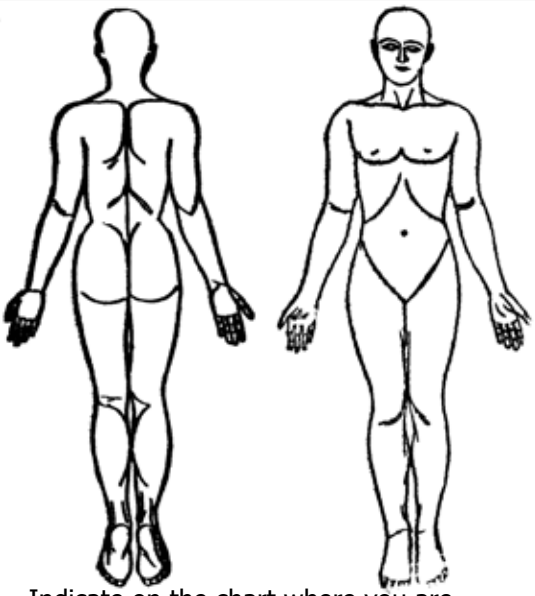
Have you already had medical intervention for this? Describe what was tried and if it has helped

Doctor/Massage Therapy/Physical Therapy/Chiropractic/Naturopath/Other

Aching: OOO Stabbing: XXX Shooting: ☐☐☐ Burning: ### Numbness and Tingling: ≈≈≈

Rate your pain on a scale 1-10 (1: almost no pain, 10: worst pain ever).....

Have you had any X-ray/CT/MRI for this condition? When? Where?



Indicate on the chart where you are having your symptoms.

Consent to treatment and Fees:

I consent to participate in physiotherapy assessment and treatment by Lenora Klassen BScPT. I understand that my physiotherapist will collaborate with me in making decisions regarding my assessment and treatment and that I should discuss any questions or concerns regarding my treatment with her. Should I choose not to participate in any portion of my treatment program, I must inform my physiotherapist immediately.

Signed:_____ Date:_____

I consent to pay the specified fees indicated below.

$60 per half hour treatment

$35 for a missed appointment with less than 24 hr. cancellation notice (online change or by phone or in person)

Signed:_____ Date:_____

For electronic submission: typed name and date becomes signature

SUBMIT form by email

feel better LK Physio

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