NW Chiropractic and Massage

Physiotherapy Intake Form

PATIENT INFORMATION

Name: _____ **Alberta Health Care #:** _____

Address: _____ **City:** _____ **Postal Code:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Date of Birth: _____ **Age:** _____ **Sex:** ☐ **Male** ☐ **Female**

Occupation: _____ **Employer:** _____

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

MEDICAL INFORMATION

Family Doctor's Name: _____ **Clinic Name:** _____

Date of Last MD Visit: _____ **Date of Last Physical:** _____

What Medications Are You Taking? _____

Do you consent to allow us to contact your medical doctor? ☐ Yes ☐ No

Which Other Therapies Have You Received:

☐ **Chiropractic** ☐ **Massage** ☐ **Physiotherapy** ☐ **Acupuncture** ☐ **Other** _____

Which Other Therapies Are You Interested In:

☐ **Massage** ☐ **Physiotherapy** ☐ **Acupuncture** ☐ **Other** _____

HOW DID YOU FIND US?

☐ **Referred by Family / Friend** ☐ **Referred by MD** ☐ **Internet / Website**

☐ **Referred by Trainer** ☐ **Walk In** ☐ **Other** _____

Whom May We Thank For The Referral? _____

CONDITION OR INJURY INFORMATION

Reason For Your Visit: _____ **When Did This Begin?** _____

Have You Had This Before? ☐ **Yes** ☐ **No** **When?** _____

Is It Getting: ☐ **Worse** ☐ **Better** ☐ **Unchanged**

Is This Related To: ☐ **Work Injury** ☐ **Auto Accident**

Have You Seen Anyone Else For This Condition: ☐ **Yes** ☐ **No** **Who?** _____

What Does Your Pain Feel Like? (check all that apply)

☐ **Tight and Stiff** ☐ **Dull / Achy** ☐ **Sharp** ☐ **Pins and Needles** ☐ **Numb** ☐ **Burning**

☐ **Other** _____

What Aggravates Your Pain?

☐ **Sitting** ☐ **Standing** ☐ **Walking** ☐ **Lifting** ☐ **Exercise** ☐ **Weather Change** ☐ **Rest**

☐ **Other** _____

What Relives Your Pain?

☐ **Rest** ☐ **Movement** ☐ **Ice** ☐ **Heat** ☐ **Medication** ☐ **Other** _____

PLEASE RATE YOUR PAIN:

Least Pain **0 1 2 3 4 5 6 7 8 9 10** Most Pain

Does This Condition Interfere with: ☐ **Work** ☐ **Family / Social Life** ☐ **Sport / Hobby** ☐ **Sleep**

What Do You Think Caused This Condition? _____

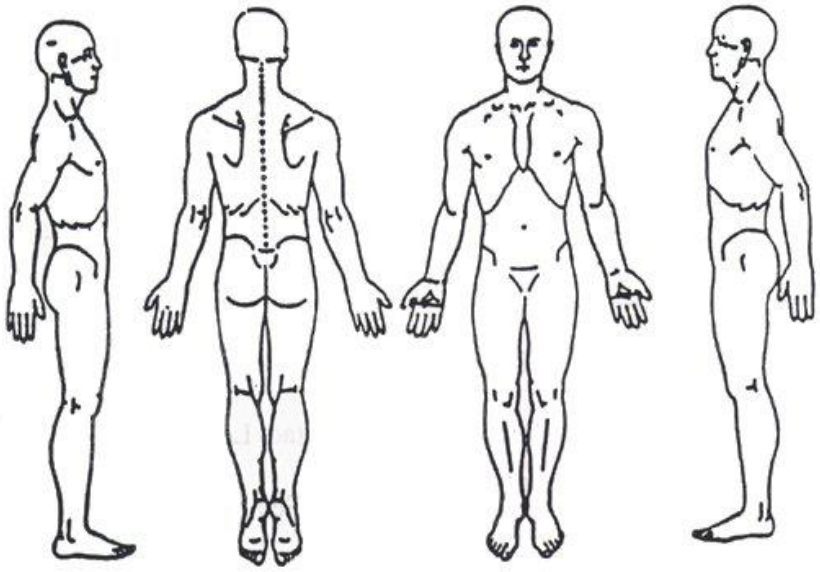
What Is This Condition Stopping You From Doing? _____

Please List Any Secondary Complaints: _____

_____

PLEASE INDICATE ON THE DIAGRAM THE AREAS YOU FEEL PAIN, TENSION, DISCOMFORT

Numbness	≡≡≡≡	Pins/Needles	~~~~	Burning	oooo
Sharp	xxxx	Dull/Achy	ΔΔΔΔ	Stiff/Tight	2222



HEALTH HISTORY:

At Any Time In The Past, Have You:

Had Surgery: ☐ Yes ☐ No **Had a Fracture:** ☐ Yes ☐ No

Been Hospitalized: ☐ Yes ☐ No **Been in a Car Accident:** ☐ Yes ☐ No

Had a Concussion: ☐ Yes ☐ No **Explain The Above:** (When, Where, Why) _____

Have You Been Diagnosed With:

☐ Cancer ☐ HIV / Aids ☐ Hepatitis ☐ Other

☐ High Blood Pressure: ☐ High Cholesterol

☐ Are You Pregnant? **Due Date:** _____ **# Of Previous Pregnancies:** _____

 # Of Children: _____

☐ Allergies **Please List:** _____

Is There a Family History Of:	Heart Disease	Stroke	Cancer	Diabetes	Arthritis	Other
Mothers Side:	☐	☐	☐	☐	☐	☐
Fathers Side:	☐	☐	☐	☐	☐	☐

LIFESTYLE:

Are You Currently a Smoker? ☐ Yes ☐No **Were You Ever a Smoker?** ☐ Yes ☐No

Do You Consume Alcohol? ☐ Yes ☐No

Do You Exercise? ☐ Yes ☐No **Rate Your Stress Level:**

How Often? _____ ☐Extreme ☐High ☐Moderate ☐Low ☐None

GENERAL HEALTH SURVEY:

Musculo-Skeletal

☐ Low Back Pain
☐ Mid Back Pain
☐ Neck Pain
☐ Joint Pain
☐ Walking Problem
☐ Clicking Jaw
☐ TMJ Pain
☐ Sciatica
☐ Fibromyalgia
☐ Arthritis
☐ Gout

Neurological

☐ Numbness
☐ Paralysis
☐ Dizziness
☐ Forgetfulness
☐ Fainting
☐ Convulsions
☐ Nausea
☐ Loss of Balance
☐ Cold / Tingling Extremities

Ear/Nose Throat

☐ Vision Problems
☐ Dental Problems
☐ Sore Throat
☐ Ear Aches
☐ Ear Infections
☐ Hearing Problems
☐ Stuffed Nose
☐ Sinus Infections
☐ Ringing in Ears

Respiratory

☐ Chest Pain
☐ Short Breath
☐ Lung Problems / Congestion
☐ Asthma
☐ Coughing up Blood
☐ Coughing up Phlegm
☐ Chronic Cough

Cardiovascular

☐ Blood Pressure Problems
☐ Irregular Heartbeat
☐ Heart Problems
☐ Ankle Swelling
☐ Varicose Veins
☐ Chest Pain
☐ Previous Heart Attack
☐ Previous Stroke

General

☐ Allergies
☐ Loss of Sleep
☐ Fever
☐ Headaches
☐ Night Pain
☐ Anxiety
☐ Depression
☐ Fainting
☐ Loss of Weight

Genito-Urinary

☐ Bladder Problems
☐ Painful / Excessive Urination
☐ Discoloured Urine
☐ Blood in Urine
☐ Menstrual Cramps
☐ Kidney Infection
☐ Irregular / Absent Cycle
☐ Painful Breasts
☐ Prostate Problems

Gastro-Intestinal

☐ Poor Appetite
☐ Excessive Appetite
☐ Excessive Thirst
☐ Vomiting
☐ Diarrhea
☐ Constipation
☐ Liver Problems
☐ Bloating
☐ Heartburn
☐ Black / Bloody Stool
☐ Colitis
☐ IBS
☐ Crohn's