CONFIDENTIAL CLIENT INTAKE FORM

Client ID# ______________________

Date: ______________________

Client Name: ______________________ **Date of Birth:** ______________________

Home Address: ______________________ **Postal Code:** ______________________

Home Phone: ______________________ **Cell Phone:** ______________________

Business Phone: ______________________ **Email Address:** ______________________

Employer: ______________________

Occupation: ______________________ Years in this job?: ______________________

Specialist/Physician's Name (if applicable): ______________________ Phone: ______________________

Family Physician's Name: ______________________ Phone: ______________________

Has there been any change in your health in the last year? ❍ YES ❍ NO

If YES, please elaborate: ______________________

Who referred you to our clinic? ______________________

Body part to be assessed? ______________________

Injury/condition a result of: ❍ MVA ❍ Work ❍ Sport ❍ Other

Have you had any DIAGNOSTIC TESTING (e.g. X-Rays, CT, MRI, etc) for this injury? ❍ YES ❍ NO

If YES, please indicate WHAT, WHERE and WHEN you had done: ______________________

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MEDICATIONS - Please list ALL medications you are currently taking

Medication	Dosage	Reason for Taking	Prescribing Doctor

ALLERGIES - Are you allergic or have you reacted adversely to any of the following?			
	Yes	No	Others (please list)
Latex Gloves			
Band Aids or Tape			
Skin Lotion			

GENERAL HEALTH - Do you have or have you had any of the following conditions?					
	Yes	No		Yes	No
Alcohol Dependency			Heart Murmur		
Anemia			Heart Surgery		
Angina			Heart Attack		
Arthritis			Hepatitis A/B/C		
Artificial Joint(s)			High Blood Pressure / Heart Trouble		
Asthama			HIV (Aids)		
Cancer			Kidney Trouble / Transplant		
Diabetes or Excessive Thirst			Liver Disease / Transplant		
Do you smoke?			Mitral Valve Prolapse		
Drug Addiction			Pacemaker		
Eating Disorders			Persistent Cough		
Emphysema / Bronchitis			Psychiatric Treatment		
Epilepsy / Seizures			Rheumatoid Condition(s)		
Excessive Bruising			Recent Infection or Illness		
Fainting or Dizziness			Stomach Ulcer		
Loss of Consciousness			Stroke		
Glaucoma			Thyroid Disease		
Haemophilia (blood bleeding disorder)			Tuberculosis		

Do you have any disease, condition or problem not listed above which you think we should know about?
❍ YES ❍ NO Please list.

FOR WOMEN ONLY:
Are you pregnant? ❍ YES ❍ NO If YES, when are you due? _______ **Are you nursing?** ❍ YES ❍ NO

Have you ever had surgery or been hospitalized? ❍ YES ❍ NO
If YES, (a) When (b) What was the illness or operation?

Have you had any serious trouble with any other form of treatment? ❍ YES ❍ NO Please list.

Have you received or are you presently receiving any other form of treatment for your current condition?
❍ YES ❍ NO Please list.

Please list any activities/job duties that you have stopped/changed due to your current condition:

If you have any questions regarding the above information, please feel free to consult with your therapist.

I understand the above information is necessary to provide me with physiotherapy care in a safe manner. I have answered all questions truthfully and to the best of my knowledge.

Signature:

Please confirm your signature by typing your full legal name above

Date: