INTAKE FORM

Name _____ DOB (dd/mm/yyyy) _____

Adress: _____ City: _____ Postal Code: _____

Home phone: _____ Alternate phone: _____

Occupation: _____ Email (optional) : _____

(appointment reminders, exercises, notices)

Physician's Name: _____

Personal Health Number (PHN) _____ **Emergency contact**: _____

(Name, Telephone)

Previous therapies: ○ Physiotherapy ○ Chiropractic ○ Acupuncture ○ Other

Please include therapist's name & date of last visit _____

_____

_____

Please indicate the nature of your visit:

- ○ **Symptom Relief** "I am only looking for some temporary relief."
- ○ **Preventative Care** " I enjoy feeling strong and flexible, and want to remain active."
- ○ **Resolution** "I currently have an injury that I would like to recover from."

Medical History: Please **circle** current complaints, and **check off** past complaints.

- ○ Abdominal complaints
- ○ Angina
- ○ Athritis
- ○ Asthma
- ○ Artificial joint replacements
- ○ Balance disorder
- ○ Blurred vision/Double vision
- ○ Cancer/Family history of cancer
- ○ Chest pain
- ○ Concussion
- ○ Currently pregnant
- ○ Diabetes
- ○ Difficulty swallowing
- ○ Dislocations
- ○ Dizziness
- ○ Fractures
- ○ Gastrointestinal disorders
- ○ High/Low blood pressure
- ○ Headaches
- ○ Heart disease
- ○ Herniated disc
- ○ Hot/Cold intolerance
- ○ Nausea/Vomiting
- ○ Neurological disorder
- ○ Osteoporosis/Low bone density
- ○ Numbness/tingling
- ○ Pacemaker
- ○ Polio/Post Polio Syndrome
- ○ Psychiatric or Psychological care
- ○ Recent weight loss
- ○ Respiratory condition
- ○ Seizures
- ○ Shortness of breath
- ○ Skin condition
- ○ Sleep disorder
- ○ Stroke
- ○ Ulcers
- ○ Vascular disease
- ○ Other

Please list current medications being taken: _____

_____

How did you hear about our clinic? ○ Internet ○ Newspaper ○ MD ○ Friend ○ Other _____

Fee Policy:

In consideration of your fellow patients and your therapist, please allow a minimum of 24 hours notice to change or cancel your appointment. You will be charged the full treatment fee for late cancellations or missed appointments, subject to the discretion of your therapist. Please inform us if you are unable to attend your appointment. I hereby acknowledge that I have read and agree with the fee policy.

Patient signature: _____ Date: _____

Please note: For your convenience, if you are seeing multiple therapists, this intake form may be shared.