ActiveLife PHYSIOTHERAPY & WELLNESS

CLIENT INTAKE FORM

Name:______________________________ Date of Birth:___________________

Home Address:____

Telephone (H):_____________ (W):____________ Email:___________________

Family Doctor: _______________________ Referring Doctor:________________

Employer/Position:___________________ WHSCC Claim #:_________________

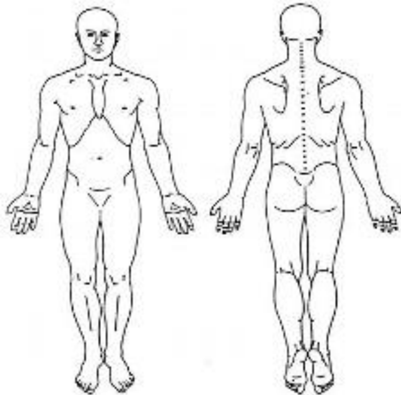
Personal Insurance Provider: ___________ MCP Number : ___________________

Present Injury/ Impairment(s)

When and How symptoms occurred: ______________________________________

What makes the above: BETTER_______________ WORSE___________________

Please **shade** where symptoms occur:



Please list any tests performed (x-ray, MRI, ultrasound, CT Scan, EMG, etc):

____

____

Please list medications:

____

____

Please list past surgeries:

____

Medical History - check which apply:

- ○ Pregnant
- ○ High blood pressure
- ○ Pacemaker or other implants
- ○ Heart attack/angina
- ○ Stroke
- ○ Abnormal heart rate or other heart conditions
- ○ Depression or anxiety disorder
- ○ Cancer
- ○ Arthritis

- Osteoporosis
- Diabetes (indicate which type)
- Other: ___________________

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Have you experienced any of the following symptoms, if yes, please indicate which ones:

- ○ Headaches
- ○ Unexplained weight loss
- ○ Night sweats or fever/chills
- ○ Difficulty swallowing or speaking
- ○ Blurred vision
- ○ New growths or lumps
- ○ Fatigue
- ○ Dizziness or nausea
- ○ Shortness of breath or chest pain
- ○ Constant pain through the night
- ○ Fainting
- ○ Change in bladder or bowel function

Rehabilitation Plan and Goals

Please list functional tasks as well as activities that have been affected by your injury or impairment (s):

____

____

Please list at least two goals you would like to achieve during your rehabilitation:

1. ____

2.____

3. ____

4.____

Client Signature : ___________________________ Date: _____________________

Physiotherapist Signature : ___________________ Date:______________________