Medhealth Physiotherapy Initial Intake

Patient Name: _____Date_____

ADDRESS: _____

D.O.B. (d/m/y) _____Age: _____Occupation:_____

Employer _____

HOME/CELL PHONE_____ Email _____

What brings you to the clinic today :

_____

_____

Current Condition/ Injury: *Check which applies*

1) Work Car Accident Sports Others

2) Sudden Onset Gradual onset?

3) When did your injury/ condition occur?

4) Area of original injury/ condition?

5) Has the injury/ condition spread?

6) How are the symptoms since onset? Better Same Worse

7) Has this injury/ condition happened before? Yes No

History of treatment:

1) Any current medication(s) for this problem:

2) Any medication(s) for other problem(s):

3) X-rays for current problem? Yes No Results

4) Any other tests for current problem (CT scan, MRI, EMG, US): Yes No

Describing the pain

1) Aching Burning Throbbing Stabbing Tingling

2) Deep or Superficial

3) Constant or Intermittent

On the scale of zero (no pain) to ten (worse pain imaginable) describe the intensity of your pain:

0 1 2 3 4 5 6 7 8 9 10 At its Best: At its Worse:

Assessing your symptoms:

1) Aggravating factors (what makes your pain worse?)

2) Alleviating factors (what makes your pain better?)

3) Worst time of the day is?

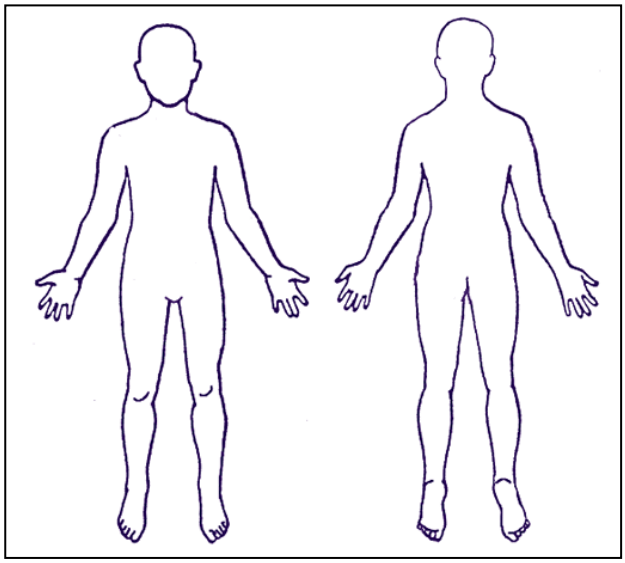
Morning Afternoon Evening Night

4) Does the pain disrupt your sleep? Yes No

Describing your symptoms

Draw circles around the affected body parts, and indicate the letter which best describes your symptoms

Discomfort = D
Soreness = So
Stiffness = St
Spasm = Sp
Tightness = T
Tingling = Ti
Numbness = N
Weakness = W
Pain = P
Other =
(Add your own description)



Check those that apply to your job:

Sedentary Active Very Active

Prolonged sitting Prolonged standing Prolonged walking

Repetitive lifting Repetitive bending Repetitive twisting Repetitive carrying

Are you currently: Off Work On modified hours/duties

Describing Activities Outside Work:

Type/ frequency of exercise:

Please advise your Health Practitioner if any of the following conditions exist as they may interfere with your treatment

Do you have:

Yes No Metal implants such as pins, plates, and/ or wires
Yes No Pace Maker or Defibrillator
Yes No Joint Replacement

Have you ever had or are you currently being treated for:

Yes No High Blood Pressure
Yes No Low Blood Pressure
Yes No Diabetes
Yes No Tuberculosis
Yes No HIV/ AIDS
Yes No Hepatitis Type
Yes No Heart Problems
Yes No Kidney Problems
Yes No Cancer: Where & When
Yes No Hyper or Hypothyroidism
Yes No Stroke: When
Yes No Hemophilia

Are you on any medications or using any topical applications regularly such as:

Yes No Cortisone (pills or recent injections)
Yes No Aspirin
Yes No Tranquilizers
Yes No Muscle Relaxants
Yes No Pain Killers
Yes No Tetracycline
Yes No Antibiotics
Yes No Liniment

Family Medical History

Smoker: (Y/N) How many per day/ week

Alcohol use: (Y/N) How many per week

Do you have any allergies that you are aware of? Please List:

Do you have any other medical conditions that you want us to be aware of?

For Women Only: Yes No Do you suspect you may be pregnant?

Patient Name:

Patient Signature: **Date:**