MEDHEALTH PHYSIOTHERAPY
HEALING HANDS & LISTENING HEARTS

INITIAL INTAKE FORM

Patient Name: ____Date_______________________

Address: ____

City: ______________________________ Postal Code: _________________________

D.O.B. (d/m/y) _____________________Age: _______Occupation:____________________________________

Name of Family / Referring Doctor:____

Employer ____

Cell Phone_________________________________Email ____

☐ I would like to receive appointment reminders via SMS/Text Messaging.

Emergency Contact Information

Emergency Contact Name & Relationship: ____

Phone Number: ____

Insurance Information

Extended Health Insurance Company: ____

Policy #: ____________________________ Certificate #: _____________________

Name of Policy Holder: ______________________ DOB: _______________________

Relationship to Policy Holder: ____

☐ I have a secondary Insurance Policy available

Motor Vehicle or WSIB Claim Information **(If Applicable)**

Date of Injury/Accident (YYYY-MM-DD): ______________________________________

Claim #: ________________________ Policy # (MVA Only): _____________________

Insurer (MVA Only): ____

Adjuster Name: ___________________________Adjuster Phone #: ____________________________

Current Condition/ Injury: *Check which applies*

1) What brings you to the Physio clinic today:

2) Work Car Accident Sports Others

3) Sudden Onset Gradual onset?

4) When did your injury/ condition occur?

5) Area of original injury/ condition?

6) Has the injury/ condition spread?

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

8) 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 Tinglin
g

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?)

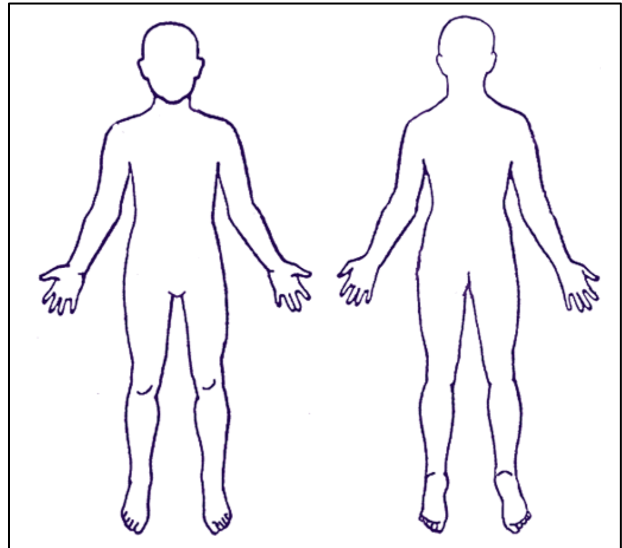
3) Worst time of the day is?

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/Guardian Signature: **Date:**