



MEDHEALTH PHYSIOTHERAPY

HEALING HANDS & LISTENING HEARTS

PHYSIOTHERAPY INITIAL INTAKE FORM

Patient Information

Patient Name	Date
Address	City / Postal Code
Date of Birth (DD/MM/YYYY)	Age
Occupation	Family / Referring Doctor

Contact Information

Cell Phone	Email
Employer	Occupation

Emergency Contact

Contact Name / Relationship	Phone Number
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Insurance Information

Insurance Company	Policy #
Certificate #	Policy Holder Name
DOB of Policy Holder	Relationship to Policy Holder

Current Condition / Injury

Describe your injury or concern:

Cause: <input type="checkbox"/> Work <input type="checkbox"/> Car Accident <input type="checkbox"/> Sports <input type="checkbox"/> Other	Onset: <input type="checkbox"/> Sudden <input type="checkbox"/> Gradual
Date of Injury	Area of Injury
Symptoms Since Onset: <input type="checkbox"/> Better <input type="checkbox"/> Same <input type="checkbox"/> Worse	Previous Occurrence: <input type="checkbox"/> Yes <input type="checkbox"/> No
Has the pain spread?	Worst time: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night
Any Imaging done (Xray, MRI , Ultrasound) When?	

Pain Assessment

Pain Scale (0 = No Pain, 10 = Worst Pain)

Current	Best	Worst
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Type of Pain / Symptoms (Check all that apply):

- Aching Sharp Dull Burning Stabbing Throbbing Shooting Cramping
 Pressure Tightness Stiffness Tingling Numbness Weakness Radiating Other:

Pattern: Constant Intermittent

Aggravating / Relieving Factors

What makes the pain worse?

What makes the pain better?

Work & Activity

Job Type: <input type="checkbox"/> Sedentary <input type="checkbox"/> Active <input type="checkbox"/> Very Active	Work Status: <input type="checkbox"/> Off Work <input type="checkbox"/> Modified Duties
Physical Demands: <input type="checkbox"/> Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Walking	<input type="checkbox"/> Lifting <input type="checkbox"/> Bending <input type="checkbox"/> Twisting <input type="checkbox"/> Carrying
Exercise / Physical Activity	

Medical History

Metal Implants <input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No
Joint Replacement <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No

Any Other Conditions which we should know:

For Female Patients: Do you suspect you may be pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Lifestyle & Additional Information

Known Allergies: _____

Current Medications: _____

Therapist Notes / Additional Comments:

Consent to Treatment

I consent to physiotherapy assessment and treatment. The therapist has explained the purpose and I understand I may ask questions or withdraw consent at any time.

Patient / Guardian Name	Signature	Date
Therapist Name & Designation	Therapist Signature	Date