Body 'n Balance Physiotherapy
Patient Intake Form

Patient Information

Last Name: First: Date of Birth (M/D/YR): Age: Sex: ☐ M ☐ F

Street Address: City/Town: Province:

Postal Code: Home Phone #: Work/Cell #: E-mail Address:

Emergency Contact: Relationship: Home Phone # Work/Cell #:

Family Doctor: Surgeon Name (*if applicable*):

Are you currently seeing another health care provider: ☐ Chiropractor ☐ Naturopath ☐ Other:_____

Have you received Physiotherapy before? ☐Yes ☐No Have you received Massage Therapy before? ☐Yes ☐No

Medications / Supplements / Homeopathic remedies taken? Reason for taking them?

1. _____ _____
2. _____ _____
3. _____ _____

Do you exercise / stretch regularly? ☐ Yes ☐ No Describe: _____

What is your stress level from 0 – 10 (0 = No Stress, 10 = High Stress): _____

How did you hear about our services / clinic? ☐ Doctor:_____ ☐Advertisement/Newspaper

☐ Friend/Family ☐ Drove By/Signage ☐ Yellow Pages ☐ Internet/Web Page ☐ Radio Ad

☐ Here Before ☐ Other: (Please Specify):

Reason for Visit

Current Medical Complaint: _____

How long have you had this condition/injury? _____

Surgery type and date (*if applicable*): _____

Check the appropriate box(s) that describe your pain:

Sharp	☐	Shooting	☐	Aching	☐	Dull	☐
Throbbing	☐	Burning	☐	Well Localized	☐	Constant	☐
Deep	☐	Superficial	☐	Poorly localized	☐	Intermittent	☐

Indicate on the scale below your current level of pain:

No Pain/___/___/___/___/___/___/___/___/___/___/___/ Worst Pain Imaginable

0 1 2 3 4 5 6 7 8 9 10

What Increases your pain? _____

What Decreases your pain? _____

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Past/Current Medical History

Cardiovascular

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Chronic Congestive Heart Failure
- ☐ Heart Attack(s)
- ☐ Phlebitis / Varicose Veins
- ☐ Stroke / CVA
- ☐ Pacemaker or Similar Device
- ☐ Heart Disease
- ☐ Shortness of Breath

Head / Neck

- ☐ Headache
- ☐ Migraine ☐ With Aura
- ☐ Vision Problems
- ☐ Contact Lenses
- ☐ Earaches
- ☐ Hearing Problems
- ☐ Herniated Disc

Respiratory

- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Digestive / Urinary

- ☐ Urinary Tract Infection (UTI)
- ☐ Constipation
- ☐ Crohn’s Disease / Colitis
- ☐ Liver / Gall Bladder
- ☐ Diabetes
- ☐ Ulcers

Skin

- ☐ Skin Conditions
  Types:_____
  _____
- ☐ Bruise Easily
- ☐ Planter Warts
- ☐ Rashes
- ☐ Loss of Sensation
  Where: _____
- ☐ Eczema / Psoriasis
  Where: _____

Female Only

- ☐ Menstrual Problems
  - ☐ Painful
  - ☐ Heavy
  - ☐ Scant
- ☐ Pregnancy
  Due Date: _____
- ☐ Menopausal Problems

Surgical Implants

- ☐ Pins
- ☐ Wires
- ☐ Artificial Joints / Limbs
- ☐ Other: _____

Other Conditions

- ☐ Hemophilia
- ☐ Epilepsy
- ☐ Herniated Disc
- ☐ Cancer
  Location: _____
- ☐ Arthritis
  - ☐ RA ☐ OA
  - ☐ Other: _____
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Chronic Fatigue Syndrome
- ☐ Polio, Post-Polio Syndrome
- ☐ Scoliosis
- ☐ Carpal Tunnel Syndrome
- ☐ Hypersensitive Reactions
- ☐ Vertigo
- ☐ Anaphylaxis
- ☐ Allergies _____
- ☐ Other: _____
  _____

Cancellation Policy

Please Note: Your appointment time has been specifically set aside for you alone. If you cancel an appointment with less than 24 hours of notice we reserve the right to charge a nominal fee of $25, due at the next session.

I have read and understood the above statement and agree to abide by the policy.

Signature _____ Date _____

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Consent for Assessment and Treatment

I, _____, authorize the Physiotherapists, Massage Therapists and/or Athletic Therapists at Body ‘n Balance Physiotherapy to assess and treat me. I understand that I have the right to refuse any assessment procedures or treatment. If I’m receiving Physiotherapy, I am aware that physiotherapy assistants/aids may assist in my treatment, and I consent to having physiotherapy assistants/aids assist with my treatment (Ultrasound, T.E.N.S., N.M.E.S., Biofeedback, Hot packs, Cold packs, and Exercises) under the direction of a Physiotherapist/Athletic Therapist. I understand that during the course of the treatment I am encouraged and have the right to ask questions about the procedure or effects of my treatment. At any time before or during, I can ask the therapist to alter or stop the treatment. **I am also aware that I may revoke my consent at any time.**

If I’m receiving massage therapy by a R.M.T., I consent to treatment of gluteus and abdominal muscles, breast or chest tissue.

_____ *(please initial if applicable)*

Signature _____ Date _____

Personal Health Information Consent

Please Initial next to A, B, C, as appropriate, and sign below.

_____ **A. Authorization to contact my doctor and other involved healthcare professionals:**
I authorize Body ‘n Balance Physiotherapy to share my personal information with any other Healthcare professionals involved in my care. Body ‘n Balance cares about your privacy and will only share information in order to facilitate best treatment.

_____ **B. Authorization to request & receive copies of my Diagnostic Imaging:**
I authorize Body ‘n Balance Physiotherapy to contact the imaging department of my Hospital or private imaging company in order to request copies of reports related to my injury or impairment. Requested reports may include but are not limited to X-ray, MRI, CT scan, and ultrasound.

_____ **C. Authorization to contact my Insurance Company / Case Manager(s) / Lawyer(s):**
I authorize Body ‘n Balance Physiotherapy to contact any insuring agency involved in my claim. Examples of insuring agencies include, but are not limited to, Extended Health, Motor Vehicle, and WSIB.

The purpose of any of the above contact will be to facilitate effective assessment, treatment, or other services for me. Contact with any of the above may occur via mail, email, fax, or voice.

By signing below I am indicating that I have read, understood, and consent to the above initialed sharing of information.

**** Before signing below, ensure that you have initialed the 3 sections above if applicable ****

Signature _____ Date _____