NorthShore HealthAssociates

Physiotherapy Intake

Date: | Patient #

Personal History

Name: _____ Address: _____
City: _____ Province: _____ Postal Code: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____ Birthdate: ____/____/____ Age: _____
(day / month / year)

Sex: ☐ Male ☐ Female Circle One: Married Single Widowed Divorced Seperated Other # of Children: _____
Family Physician: _____ Business / Employer: _____
Business Phone: _____ Type of Work: _____
Name & # of Emergency Contact: _____ Relationship: _____
Extended Health Coverage: ☐ Yes ☐ No Insurer: _____
Who may we thank for referring you to this office: _____

Current Health Condition

Current Complaint: _____
Are you here for: ☐ Physiotherapy ☐ Laser ☐ Spinal Decompression Therapy ☐ Other _____
Other Doctors seen for this condition ☐ No ☐ Yes : Who: _____
Type of Treatment: _____ Results: _____
When did this condition begin? _____ Has this condition occurred before? ☐ Yes ☐ No
Is condition: ☐ Job-related ☐ Auto-related ☐ Home Injury ☐ Fall ☐ Other _____
Date of Accident: _____ Time of Accident: _____
What aggravates your condition? ☐ Sitting ☐ Standing ☐ Bending ☐ Lifting ☐ Walking
☐ Lying Down ☐ Cold ☐ Dampness ☐ Other: _____
What relieves your condition? ☐ Bed Rest ☐ Ice ☐ Heat ☐ Massage ☐ Medication
☐ Other: _____
Is it getting: ☐ Worse ☐ Constant ☐ Comes / Goes ☐ Better
Character of Pain: ☐ Sharp ☐ Dull ☐ Ache ☐ Pins & Needles ☐ Numb ☐ Burning
☐ Constant ☐ Intermittent
Is pain worse in: ☐ Morning ☐ Afternoon ☐ Evening
Please describe how it feels when this problem is at its worst: _____
Please place an X on the grade indicating the severity of your pain LEAST 1 2 3 4 5 6 7 8 9 10 WORST

Current Medications: ☐ Muscle Relaxers ☐ Insulin ☐ Other: _____
☐ Painkillers ☐ Nerve Pills _____
☐ Sleeping Pills ☐ Blood Pressure Meds _____
Do you suffer from any condition other than that for which you are now consulting us? _____
_____
Have you had any of the following in the last year? ☐ X-rays ☐ CT Scan ☐ MRI ☐ Diagnostic Ultrasound ☐ NCU
If yes, where & when *(approx)*? _____

Past Health History

Please check:
Major Surgery / Operations: ☐ Appendectomy ☐ Tonsillectomy ☐ Gall Bladder ☐ Hernia ☐ Back Surgery
☐ Broken Bones ☐ Cancer ☐ Other: _____
Previous: ☐ Childhood Traumas _____ ☐ Sports Injuries _____
☐ Motor Vehicle Accidents _____ ☐ Work Injuries _____
Hospitalization (other than above): _____
_____
Previous Physio Care: ☐ None ☐ Doctor's name & approx. date of last visit: _____

Family Health History

Does any member of your family suffer from the same condition? ☐ No ☐ Yes : Whom: _____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

Check any of the following diseases you have had:

- ☐ Pneumonia
- ☐ Mumps
- ☐ Influenza
- ☐ Rheumatic Fever
- ☐ Small Pox
- ☐ Pleurisy
- ☐ Polio
- ☐ Chicken Pox
- ☐ Arthritis
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Whooping Cough
- ☐ Cancer
- ☐ Mental Disorder
- ☐ Anemia
- ☐ Heart Disease
- ☐ Lumbago
- ☐ Measles
- ☐ Thyroid
- ☐ Eczema

Check any of the following you have had in the past six months:

Musculo-Skeletal Code

- ☐ Low Back Pain
- ☐ Gas / Bloating After Meals
- ☐ Pain Between Shoulders
- ☐ Heartburn
- ☐ Neck Pain
- ☐ Black / Bloody Stool
- ☐ Arm Pain
- ☐ Colitis
- ☐ Joint Pain / Stiffness
- ☐ Walking Problems
- ☐ Clicking Jaw
- ☐ General Stiffness

Nervous System Code

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion / Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold / Tingling Extremities
- ☐ Stress

C-V-R Code

- ☐ Chest Pain
- ☐ Short of Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems / Congestion / Asthma
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

General Code

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

EENT Code

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

Gastro-Intestinal Code

- ☐ Poor / Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

Male / Female Code

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramping
- ☐ Vaginal Pain / Infections
- ☐ Breast Pain / Lumps
- ☐ Prostate / Sexual Dysfunction

Genito-Urinary Code

- ☐ Bladder Trouble
- ☐ Painful / Excessive Urination
- ☐ Discoloured Urine

Females Only

When was your last period?

_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure

Intake

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Personal Satisfaction w/ Diet

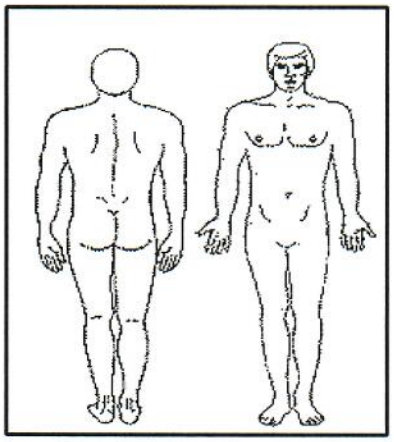
- ☐ Highly Satisfied
- ☐ Dissatisfied
- ☐ Highly Dissatisfied

Regular Exercise?

- ☐ Yes
- ☐ No

Lifestyle Stress Levels

- ☐ High
- ☐ Moderate
- ☐ Very Little



Please indicate on the diagram, the area of your discomfort and any radiation of pain.