Online Intake Form

Steps:

1. **Fill out the form. You can do this in your browser.**
2. **Save the file as your name. (e.g. johndoe.pdf)**
3. **Email the file to info@sportscentrephysio.com OR print and bring with you to your first appointment.**
4. **When you arrive at the clinic, we will have you sign the form.**

Thank You!

You can fill this form out on your computer and email to info@sportscentrephysio.com, or print and bring with you to your first appointment!

Name:______________________________ Date:______________

Address:______________________________

City:______________ Province:______________ Postal Code:______________

Home Phone:______________ Work Phone:______________ Cell Phone:______________

Birth Date:______________ Email:______________________________

Occupation:______________ Employer:______________________________

Emergency Contact (name/phone number):

If you are under 18:

Guardian Name:______________ Relationship to guardian:______________

Guardian Address:______________________________

City:______________ Province:______________ Postal Code:______________

Emergency contact number:______________________________

Insurance information:

Insurance Provider:______________________________

Referring Doctor:______________ Family Doctor:______________

How did you hear about Sports Centre Physiotherapy?

Friend: Coach: Doctor's Referral: Internet: Facebook:

Yellow Pages: Signage: Other (please specify):______________________________

Please accurately record the level and location of your symptom below:

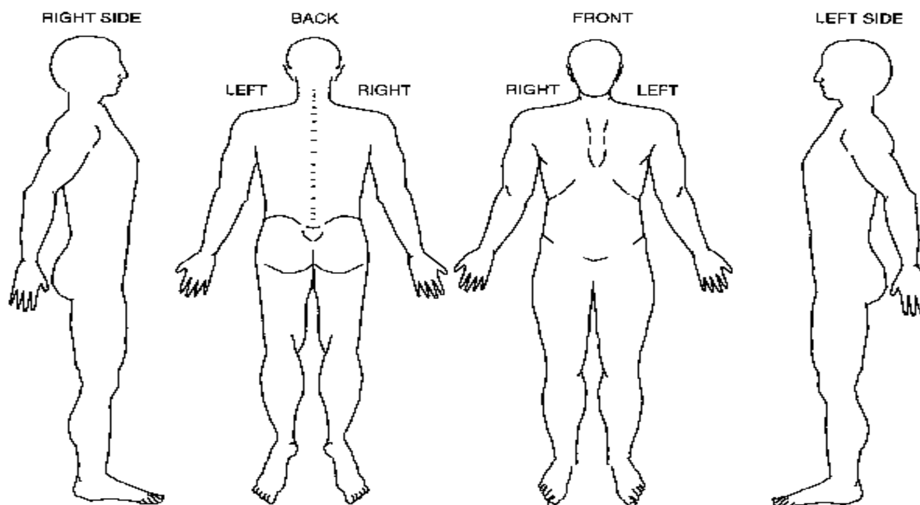
Select the box that corresponds to your current pain level:

No Pain	1	2	3	4	5	6	7	8	9	10	Severe Pain

What body part(s) are you seeking treatment for?

What type(s) of symptom(s) are you experiencing?

Check all boxes that correspond to the areas that you are experiencing pain, numbness, or tingling:



General Health Questionnaire:

This form is CONFIDENTIAL. Select the appropriate answer below.

Blood pressure: Low Normal High

Heart attack: Yes No If **yes**, when did it occur and is your heart stable?____________________________

Pacemaker: Yes No

Asthma: Yes No Other lung conditions:____

Cancer: Yes No If **yes**, when and where?____

Epilepsy: Yes No If **yes**, what type and are your seizures controlled?___________________________

Diabetes: Yes No If **yes**, what type and is it well controlled?___________________________________

Arthritis: Yes No If **yes**, what type and what joints are affected?_______________________________

Osteoporosis: Yes No Is **yes**, where? Do you have fractures?_____________________________________

Haemophilia: Yes No

Allergies: Yes No If **yes**, what are you allergic too?____

Skin Conditions: Yes No If **yes**, what conditions do you have?___________________________________

Are you pregnant or possibly pregnant? Yes No

Infectious Diseases: Yes No If yes, which one/s?____

Have you ever been previously treated by a physiotherapist, chiropractor, massage therapist, acupuncturist, osteopath, or any other professional for an injury? If yes, when, and what injury?

Please list current medications or those recently taken:

Other comments:

Please sign on the line below to consent to treatment (parent's/guardian's signature if patient is under 18):

____

***to be signed upon arrival at Sports Centre Physiotherapy**

Therapists Only:

Therapist:____

Diagnosis:____________________ Injury Date:____________________ Body Part:____________________

Sport Injury: Yes No If yes, what sport?____________________

WCB: Yes No MVA: Yes No

Receptionist:____