PATIENT INTAKE FORM

Cindy Robinson
PHYSIOTHÉRAPIE | PHYSIOTHERAPY

Date : _____

Surname : _____ Name : _____ Sex (F/M) : ___

Age : ____ Date of birth : _____

Address :_____City : _____Postal Code: _____
Email address : _____
Cell phone number : _____Home : _____ Work : _____
Emergency contact (name, #) : _____Relationship to patient : _____

Occupation : _____
Activities/sports (weekly frequency) : _____
Dominance (left/right handed, ambidextrous) : _____

Reason for consultation (injury or painful area) : _____
Date of onset of symptoms : _____
Medical consult (Yes/No) : _____
Name of doctor : _____
Medical diagnostic : _____
Diagnostic test (ex : x-ray, MRI): _____

Personal and family medical history :

Please circle all that apply (past and present).

Allergies :..... Yes No
Pregnancy : .....Yes No
Concussion : ..... Yes No
Arthritis or other rheumatological conditions : ..... Yes No
Migraines/frequent headaches : ..... Yes No
Neurological : ..... Yes No
Cancer : ..... Yes No
Diabetes : ..... Yes No
Depression, anxiety, stress : .....Yes No
Recent infection (last 3 months) : .....Yes No
Hormonal (ex: thyroid) : .....Yes No
Cardiac : ..... Yes No
Respiratory/pulmonary : .....Yes No
High or low blood pressure : .....Yes No
Gastrointestinal : ..... Yes No
Urinary : .....Yes No

Other? (List) : _____
Family history of diseases or risk factors : _____
_____

For the therapist's use :

General health :

Please list any past injuries, traumas or painful episodes : _____
_____
_____

Are you taking any prescription or over-the-counter medications? Please list : _____
_____

Have you ever been hospitalized? _____
_____

Have you ever had surgery? Metal implants? _____
_____

Have you had any unexplained weight gain or loss in the past 3-6 months?_____
_____

Have you noticed any lumps, or cysts anywhere on your body? Any sores or skin changes?
_____

Do you smoke cigarettes? #packs/week : _____

How much alcohol do you drink? #drinks/week : _____

Do you use recreational drugs? What, how often? : _____

How much caffeine do you consume? #drinks/day : _____

**Tobacco, alcohol, drugs and caffeine have a detrimental effect on your health but may also alter perception of pain and delay tissue healing.*

Patient consent for treatment :
By my signature below, I consent to receive the treatments explained by my physiotherapist.

No show or cancellation :
By my signature below, I consent to advise my physiotherapist at least 24 hours in advance for a cancellation. A 40$ fee may be charged if the delay hasn't been respected. In case of a no show for treatment, the full treatment fee may be charged.

Patient's signature : _____ **Date :** _____