

Interprofessional Clinic Clinique Interprofessionnelle



Physiotherapy/Massage Intake Form

Name: _____

Date of birth (dd/mm/yyyy): _____ Occupation: _____

Home Phone: _____ Cell: _____

Address: _____

Emergency contact (name, phone number, relation): _____

Family doctor name/location: _____

Referral source (doctor, friend, website): _____

Current physical activity (IF YES please describe)? YES/NO _____

What is your primary reason for coming in today? _____

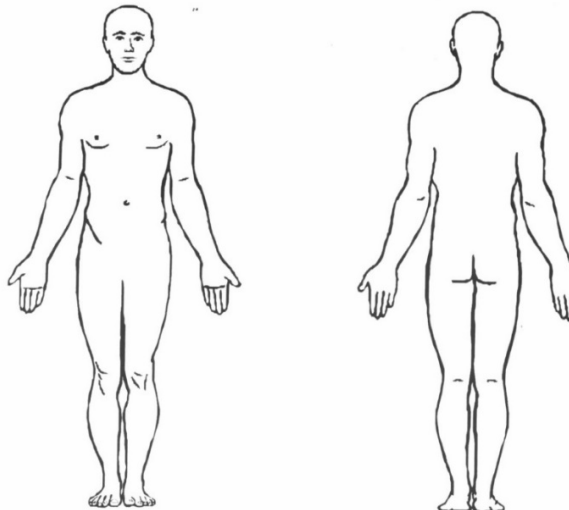
What do you hope to achieve from physiotherapy/massage? _____

On a scale from 1-10, what would you rate your current level of pain? No pain 0 1 2 3 4 5 6 7 8 9 10 extreme pain

When did your pain begin? _____ Is this a new or recurring issue? _____

How would you describe your pain? Sharp stabbing dull achy burning pins & needles numb other _____

Please shade the affected areas:



See Reverse →

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Medical History – Please check all that apply

<input type="checkbox"/> Heart Disease/Pacemaker <input type="checkbox"/> Heart attack <input type="checkbox"/> Stroke <input type="checkbox"/> High blood pressure <input type="checkbox"/> Headaches/Migraines <input type="checkbox"/> Asthma <input type="checkbox"/> Previous surgery <input type="checkbox"/> Metal Implant <input type="checkbox"/> Pregnant <input type="checkbox"/> Cancer (current or previous) <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Difficulty speaking <input type="checkbox"/> Vision difficulties <input type="checkbox"/> Unexplained weight loss or gain <input type="checkbox"/> Allergies/Skin sensitivities (<i>please specify</i>)	<input type="checkbox"/> Diabetes <input type="checkbox"/> Poor circulation <input type="checkbox"/> Decreased sensation <input type="checkbox"/> Neuropathy <input type="checkbox"/> Raynaud's <input type="checkbox"/> Smoke (current or previous) <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Arthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Concussions <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting/Blackouts <input type="checkbox"/> Hemophilia <input type="checkbox"/> Epilepsy <input type="checkbox"/> Scoliosis <input type="checkbox"/> Bowel or bladder difficulties <input type="checkbox"/> Infectious conditions <input type="checkbox"/> HIV, TB, Hepatitis <input type="checkbox"/> Other
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Please list any previous surgeries or injuries (please include approximate dates):

Please list any medications:

Privacy – Personal Health Information

Personal health information is confidential. It is important for the physiotherapist/massage therapist to know your full health history in order to provide safe and effective treatment.

By signing below, I give my consent to undergo physiotherapy/massage therapy assessment and treatment with a registered physiotherapist/registered massage therapist and that the above information is correct and accurate to the best of my knowledge.

Signature: _____ Date: _____

I give my consent for my personal health information to be shared with my family doctor or other healthcare professionals _____.

Date of initial Health History	_____
Update 1:	_____
Update 2:	_____
Update 3:	_____
Update 4:	_____
Update 5:	_____