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Patient Intake Form

By filling out this comprehensive intake form, you are helping us to provide you with more effective care. We thank you for your time and patience in doing this.

PATIENT INFORMATION Date

Full Name I go by

Care Card Number (PHN)

Birthday (mm/dd/yy) Age ☐ Male ☐ Female

Home Address

City Postal Code

Primary Telephone Cellphone

Email

Would you like an email reminder for your appointments? ☐ Yes ☐ No

Occupation Work Telephone

May doctor and/or staff contact you at work? ☐ Yes ☐ No

Name of General Practitioner (MD) Telephone

Name of emergency contact

Relation to you Telephone

Where did you hear about Living Wellness Centre?

Office use only MSP ☐ Yes ☐ No ☐ CND ☐ Jane ☐ W/C ☐ GS

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Health History

NAME Date

HEALTH ISSUES

Main Concern

Other Concern(s)

Have you ever been treated by any of the following: ☐ Acupuncturist ☐ Massage Therapist ☐ Chiropractor ☐ Naturopath

Is your condition part of an ICBC or WCB claim? ☐ Yes ☐ No (If yes, please ask for additional forms.)

MEDICATIONS Please list any medications/supplements you are taking and doses.

Medications (prescription, over the counter)

Supplements (multivitamins, gingko, etc.)

LIFESTYLE

Overall stress level ☐ none ☐ low ☐ medium ☐ high

How often do you exercise? Type of exercise

Do you currently smoke? ☐ Yes ☐ No

FOR WOMEN

Are you pregnant? ☐ Yes ☐ No ☐ Maybe if yes, due date

Do you have children? ☐ Yes ☐ No If yes, by ☐ vaginal birth ☐ caesarean birth

Menstrual cycle ☐ regular ☐ irregular ☐ painful cycle

Date of your last annual Pap/Breast exam

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Additional Health History

NAME Date

IMMUNIZATIONS

Did you receive general childhood vaccinations? ☐ Yes ☐ No

Check any other vaccines taken: ☐ Hepatitis A ☐ Hepatitis B ☐ Flu shot ☐ Others

ALLERGIES

Please list any allergies or sensitivities in the following categories.

Medications

Foods

Environmental/chemical

MEDICATIONS

Please check if you use any of the following.

☐ Alcohol ☐ Antacids ☐ Anti-inflammatories ☐ Caffeine ☐ Cortisone ☐ Laxatives
☐ Marijuana ☐ Pain relievers ☐ Sleeping pills ☐ Tranquilizers ☐ Other drugs

Were you ever on antibiotics for more than 1 month over the last 10 years? ☐ Yes ☐ No

Have you ever used probiotics (acidophilus) following antibiotic use? ☐ Yes ☐ No

FAMILY HISTORY

Please check if you have a family history of any of the following:

☐ Arthritis ☐ Asthma/allergies ☐ Cancer ☐ Depression ☐ Diabetes ☐ Drug/alcohol abuse
☐ Epilepsy ☐ High blood pressure ☐ High cholesterol ☐ Kidney disease ☐ Mental Illness ☐ Stroke
☐ I don't know my family history ☐ Other

SLEEP

Time you go to sleep Time you wake up

Do you have problems falling asleep? ☐ Yes ☐ No Staying asleep? ☐ Yes ☐ No

Do you wake well rested in the morning? ☐ Yes ☐ No

DIET

Do you follow any particular diet regimens or restrictions? ☐ Yes ☐ No

If yes, please specify:

Review of systems Please check the appropriate box for any of the following symptoms and add any comments you may feel are important.

Key: **P**=Past **N**=Now **B**=Both

P N B

General
- ☐☐☐ Insomnia
- ☐☐☐ Fatigue
- ☐☐☐ Weight loss
- ☐☐☐ Weight gain

Head
- ☐☐☐ Headache
- ☐☐☐ Dizziness
- ☐☐☐ Head trauma
- ☐☐☐ Fainting
- ☐☐☐ Migraines

Eyes
- ☐☐☐ Itching/redness
- ☐☐☐ Cataracts
- ☐☐☐ Flashes in vision
- ☐☐☐ Spots in vision
- ☐☐☐ Glaucoma

Mouth and Throat
- ☐☐☐ Bleeding gums
- ☐☐☐ Canker sores
- ☐☐☐ Colds sores
- ☐☐☐ Sore throat
- ☐☐☐ Jaw/TMJ problems
- ☐☐☐ Hoarseness
- ☐☐☐ Goiter

Nose
- ☐☐☐ Hayfever
- ☐☐☐ Loss of smell
- ☐☐☐ Nosebleeds
- ☐☐☐ Sinus problems

Lungs
- ☐☐☐ Asthma
- ☐☐☐ Shortness of breath
- ☐☐☐ Persistant cough
- ☐☐☐ Emphysema
- ☐☐☐ Bronchitis

Vascular
- ☐☐☐ Angina
- ☐☐☐ Murmurs
- ☐☐☐ Chest pain
- ☐☐☐ Palpitations
- ☐☐☐ Ankle swelling
- ☐☐☐ Cold feet/hands
- ☐☐☐ Leg cramps
- ☐☐☐ Varicose veins
- ☐☐☐ Low blood pressure
- ☐☐☐ High blood pressure

P N B

Gastro-Intestinal
- ☐☐☐ Bloating/gas
- ☐☐☐ Heartburn
- ☐☐☐ Ulcers
- ☐☐☐ Liver disease
- ☐☐☐ Gallstones
- ☐☐☐ Vomiting/nausea
- ☐☐☐ Abdominal pain
- ☐☐☐ Diarrhea
- ☐☐☐ Constipation
- ☐☐☐ Blood in stool
- ☐☐☐ Hemorrhoids
- ☐☐☐ Hernias

_____ # of bowel movements per day

Genitourinary
- ☐☐☐ Difficulty urinating
- ☐☐☐ Pain urinating
- ☐☐☐ Blood in urine
- ☐☐☐ Incontinence
- ☐☐☐ Bed-wetting
- ☐☐☐ Frequent urination
- ☐☐☐ Frequent infections
- ☐☐☐ Kidney stones

Neurological
- ☐☐☐ Seizures/epilepsy
- ☐☐☐ Strokes
- ☐☐☐ Tingling sensation
- ☐☐☐ Numbness
- ☐☐☐ Muscle weakness
- ☐☐☐ Difficulty walking
- ☐☐☐ Poor coordination
- ☐☐☐ Paralysis
- ☐☐☐ Speech problems
- ☐☐☐ Loss of memory

Muscle & Bone
- ☐☐☐ Joint pain
- ☐☐☐ Swollen joints
- ☐☐☐ Stiffness
- ☐☐☐ Muscle ache
- ☐☐☐ Foot trouble
- ☐☐☐ Bone pain
- ☐☐☐ Fractures
- ☐☐☐ Dislocations
- ☐☐☐ Gout

P N B

Skin
- ☐☐☐ Rash
- ☐☐☐ Itching
- ☐☐☐ Hives
- ☐☐☐ Change in moles
- ☐☐☐ Acne
- ☐☐☐ Psoriasis
- ☐☐☐ Eczema

Endocrine
- ☐☐☐ Diabetes
- ☐☐☐ Hypoglycemia
- ☐☐☐ Hormone therapy
- ☐☐☐ Thyroid problems
- ☐☐☐ Heat/cold intolerance
- ☐☐☐ Excessive thirst
- ☐☐☐ Excessive hunger
- ☐☐☐ Excessive sweating
- ☐☐☐ Night sweats

Emotional
- ☐☐☐ Depression
- ☐☐☐ Mood swings
- ☐☐☐ Anxiety/nervousness
- ☐☐☐ Tension
- ☐☐☐ Phobias

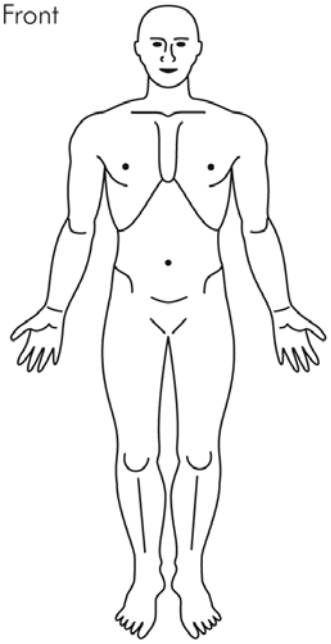
Conditions
- ☐☐☐ AIDS/HIV
- ☐☐☐ Eating disorders
- ☐☐☐ Heart disease
- ☐☐☐ Rheumatic fever
- ☐☐☐ Cancer/tumor
- ☐☐☐ Polio
- ☐☐☐ Parkinson's
- ☐☐☐ Multiple sclerosis
- ☐☐☐ Anemia
- ☐☐☐ Osteoporosis
- ☐☐☐ Osteoarthritis
- ☐☐☐ High cholesterol
- ☐☐☐ Fibromyalgia
- ☐☐☐ Chronic fatigue
- ☐☐☐ Hepatitis
- ☐☐☐ TIAs

Using the following symbols, please indicate directly on the body diagrams below the area of your complaint and the type of pain experienced.

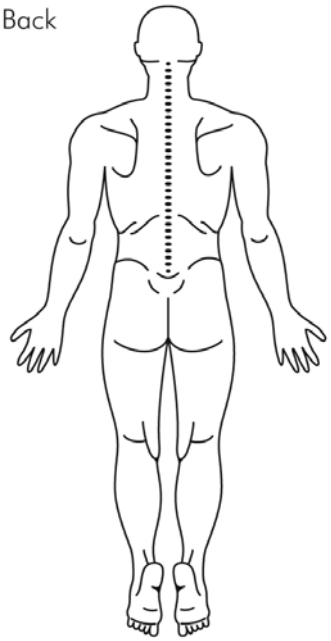
X Burning O Dull/achy

△ Sharp □ Numbness/ tingling

Front



Back



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Pelvic Floor Physiotherapy Declaration & Consent to Treatment

Please read the following carefully and enquire if you have any questions or concerns.

Statement of Acknowledgement

I hereby request and consent to the treatment and assessment of perineal and pelvic rehabilitation.

Treatment could include the following techniques including vaginal and/or anal assessment, manual therapy, exercise program, electrical stimulation, biofeedback, advice regarding current care and future prevention.

I further understand and am informed that in the practice of pelvic floor physiotherapy, as in all health care, there are some very slight risks and possible side effects to the above treatment.

I wish to rely on the PT to exercise judgment during the course of my treatment(s), to apply those treatments which he/she feels at the time, based on the facts known are in my best interest.

I have read the above statements carefully and have had the opportunity to ask questions about their contents. By signing below, I am signifying agreement to the above-mentioned pelvic floor physiotherapy, and I intend this consent to apply to and cover the entire course of treatment(s) for my present condition.

I also recognize the following:

Any treatment or advice provided to me as a patient of the clinic is not mutually exclusive from any treatment that I may now be receiving or may in the future receive from another healthcare provider licensed to practice in British Columbia.

I understand that a record of my visits will be kept. This record will be kept confidential and will not be released without my consent. I understand that I may look at my medical records at any time and can request a copy of them.

I am aware that I am responsible for payment at the time services are rendered.

I am aware that 48 hours notice must be given for cancellation of an appointment or a cancellation fee may be applied.

I understand that the PT reserves the right to determine which cases fall outside his/her scope of practice, in which event the appropriate referral will be recommended.

I also confirm that I have the ability to accept or reject this care of my own free will and choice, and that I am not an agent of any private, local, county, provincial or federal agencies to gather information without stating so. I accept full responsibility for any fees incurred during care and treatment.

Signature Date

Full Name

Physiotherapist Signature