Physiotherapy Intake

Date:

Active Touch Physiotherapy

2 Rosemount Ave Unit #14, York, Ontario, M9N3B3
(416) 200- 1044
therapy.atp@gmail.com

About You

First Name | Last Name | Pronouns

Email Address

Home Phone ( ) | Work Phone ( ) | Mobile Phone ( )

Address | City | Prov. | Postal Code

Gender | Source Of Referral | Date Of Birth D D/M M M/ Y Y Y Y | Occupation

Primary Care Info

Doctor's Name | Doctor's Phone ( ) | Doctor's Address

Emergency Contact

Emergency Contact Name | Emergency Phone ( ) | Relationship

Other Items

Health Information

Was there an incident that brought on your current problem/injury?

- ☐ Yes
- ☐ No

For how long have you been experiencing this problem?

Using the line scale provided below, rate your level of pain over the last 24 hours.

1 2 3 4 5 6 7 8 9 10

1=No Pain 10=Severe Pain

- ☐ Is your pain: Off and On
- ☐ Constant, 24 hours a day

Is your pain:

- ☐ Getting better
- ☐ Getting worse
- ☐ Staying the same

At what time of day does it seem to be at its worst?

Describe anything at work or daily activities that affect your injury/pain levels (eg. Prolonged sitting, physical demands, stress)

Are there any sports, activities or hobbies that you enjoy doing?

Conditions

Please check any of the following conditions that apply to you:

MUSCULOSKELETAL

- ☐ Sprain/Strain
- ☐ Joint Replacement
- ☐ Whiplash
- ☐ Gout
- ☐ Arthritis (OA, RA)
- ☐ Fracture, if yes where is the location?

CARDIOVASCULAR SYSTEM

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Blood Clots
- ☐ Circulatory Issues
- ☐ Varicose Veins

NERVOUS SYSTEM

- ☐ Fainting/Dizziness
- ☐ Seizures/Epilepsy
- ☐ Neurological Disorder

SKIN

- ☐ Eczema/Dermititis
- ☐ Psoriasis
- ☐ Fungal Infection

GASTROINTESTINAL SYSTEM

- ☐ Hemorrhoids
- ☐ Abdominal Pain
- ☐ Digestive Problems/IBS

OTHER

- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Cancer
- ☐ Anemia
- ☐ Hemophilia
- ☐ HIV/AIDS
- ☐ Hepatitis
- ☐ Headaches/Migraines
- ☐ Depression
- ☐ Anxiety
- ☐ Allergies, please specify.
- ☐ Pregnant

Do you have any other information that would be beneficial to YOUR treatment?

Medications

Injuries

Surgeries