Patient Intake Information

Consent to Examination

By filling out the proceeding information, you are granting **Physio F/X** voluntary consent to perform all procedures deemed appropriate to assess and treat your current area of complaint. All information obtained during this process will remain strictly confidential; and the details of your case will be limited to only those parties directly responsible for your care.

Section 1 – Personal Information

Male ☐ **Female** ☐

First Name: ______________________________ **Last Name** ______________________________

Address: ______________________________ **Home Tel:** ( ) ______-____________

City: ______________________________ **Mobile Tel:** ( ) ______-____________

Postal Code: _______ - _______ **Work Tel:** ( ) _______-___________

May we contact you at work? **Yes** ☐ **No** ☐

Date of Birth: _____ /_____ /________ (day / month / year) **E-Mail** ______________________________

Section 2 – General Health Information

Doctor's Name: ____

May we contact your Doctor? ☐ **Yes** ☐ **No**

Phone Number: ____

Office Address: ____

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☐ **Walk-In Physician** ☐ **Family Physician** ☐ **Specialist** ____________________

Is your injury the result of a motor vehicle accident (MVA)? ☐ **YES** ☐ **NO**

Section 3 - Health History

Have you ever been to a Chiropractor or Physiotherapist before? **YES** ☐ **NO** ☐

When was your last appointment? (approx.) __________________

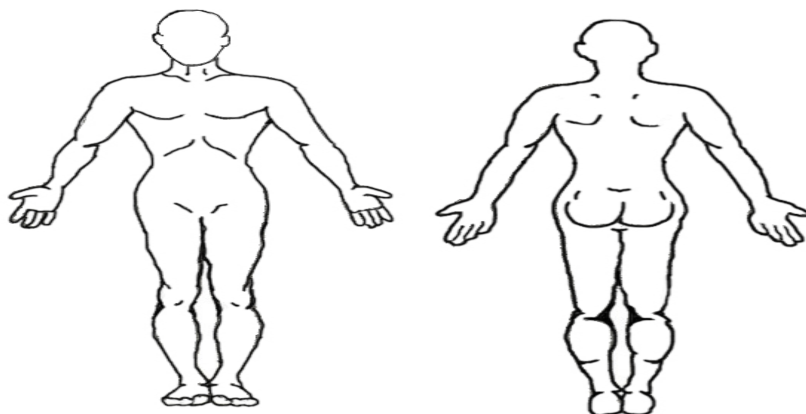
Were X-rays taken? **YES** ☐ **NO** ☐

Do you have any of the following: (Please check all that apply)

☐ Diabetes
☐ Osteoporosis
☐ High Blood Pressure
☐ Incontinence
☐ Recent Infection
☐ Recent Trauma
☐ Past Surgery
☐ History of Cancer
☐ Night Pain
☐ Unrelenting Pain
☐ Unexplained Weight Loss (>5 lbs)
☐ Age > 55 years old
☐ Smoker ______ pack-years
☐ History of Heart Disease
☐ Family History of Rheumatoid Arthritis
☐ Prolonged Use of Steroids, Corticosteroids, or Prednisone

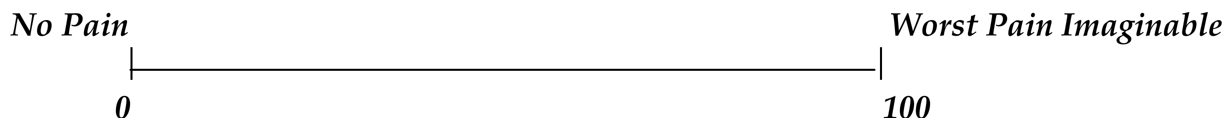
PAGE OVER ►►►

In the diagram provided below, please mark the areas on your body that you feel best represent the pain(s) or sensations(s) you are **currently** experiencing. Please include all areas.



FRONT **BACK**

How severe are your symptoms now? Please place a vertical mark along the line below to indicate how strongly you feel symptoms at this moment.



Do you have any of the following complaints, in addition to those indicated above?

- ❑ *Jaw Pain*
- ❑ *Shoulder Pain*
- ❑ *Elbow Pain*
- ❑ *Wrist Pain*
- ❑ *Back Pain*
- ❑ *Hip Pain*
- ❑ *Knee Pain*
- ❑ *Foot Pain*
- ❑ *Muscle Pain*

- ❑ *Asthma*
- ❑ *Allergies*
- ❑ *Constipation*
- ❑ *Painful Menstruation*
- ❑ *Dizziness*
- ❑ *Fatigue/Weakness*
- ❑ *Problems Sleeping*
- ❑ *Back Ache*
- ❑ *Headache*
- ❑ *Stiff Neck*

- ❑ *Arthritis*
- ❑ *Rheumatoid Arthritis*
- ❑ *Prescription Medication*

Please List: ___________________

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Have you been diagnosed with a medical disease/illness? List diagnosis and date(yr).

Please indicate any past surgery, and/or any diagnostic procedures you have had with the approximate date (yr).

Please take a moment to let us know how you heard about us by selecting an option below:

Google to Yellow Pages	**Google to Website**	**Referral**: whom may we thank? ___________________
Yahoo to Yellow Pages	**Yahoo to Website**	**Magazine**: (name) ___________________
Yellow Pages phonebook	**Building sign**	**Other:**