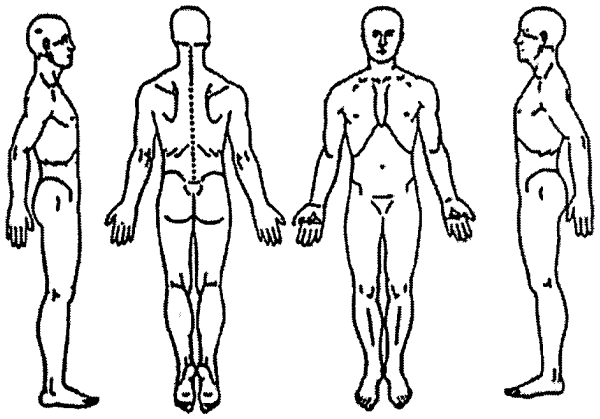
Physiotherapy Intake Form

PEAK PERFORMANCE Health Center

Name: _____
Date of Birth: _____
Family Physician: _____
Email Address: _____
Full Address: _____
Home Phone: _____
Cell: _____ Work: _____
Occupation: _____
Circle where your pain/symptoms are:



Which is your dominant Arm? ☐ Right ☐ Left

Problem:	**How did your symptoms start?**
☐ Pain ☐ Weakness ☐ numbness/tingling ☐ Instability / giving way /dislocation ☐ Stiffness ☐ Swelling ☐ Other _____ _____ _____	☐ Injury ☐ Just started hurting ☐ Sports (which) _____ ☐ Motor vehicle accident ☐ Work / Job Is there a workers compensation claim? ☐ Yes / ☐ No

Date of injury: _____ or How long have you had your symptoms? ____ Days ____ Mos _____ Yrs.
Is it better? ☐ Yes ☐ No Worsening? ☐ Yes ☐ No
Are you currently working? ☐ Yes ☐ No ☐ Limited
Return to work date: _____
Pre-injury level: ☐ desk work ☐ recreational ☐ active ☐ high level ☐ Other: _____
Briefly describe the injury: _____
_____

Diagnosis (if you know): _____
Previous treatments: (medications, Physiotherapy, Massage, Chiropractic, Injections, Bracing, Surgery): _____
_____
How severe is the pain (0 = none, 10 = severe pain)
At rest: 0 1 2 3 4 5 6 7 8 9 10
At its worst: 0 1 2 3 4 5 6 7 8 9 10
What makes your problem better? _____
_____
What makes your problem worse? _____
_____
Pain at night? _____
I sleep on my ☐ back ☐ stomach ☐ side (☐ Right ☐ Left)
☐ X-rays ☐ Cat scan ☐ MRI date: _____
Relevant Past Medical History: _____
_____
_____
Pacemaker? ☐ Yes ☐ No
History of cancer? ☐ Yes ☐ No
Where/Type: _____
What do you expect/hope to achieve from therapy?
_____
_____
Rank the following changes in order of their importance to you: (1= most important, 8= least important)
__ Decrease Pain
__ Increase Endurance
__ Increase Movement
__ Increase Work Capacity
__ Increase Strength
__ Return to Work
__ Increase ability to manipulate objects
__ Other: _____

Medications: _____
_____

I hereby request and consent to an examination and treatment performed by a licensed Physiotherapist. The results will assist the Physiotherapist in determining the appropriate physical treatment to meet my specific needs and goals. I understand that discomfort may occur following treatment and I will contact my therapist should I experience any unusual symptoms.

Patient Signature: _____