# General Intake Form – Physiotherapy & Massage

101- 602 11Ave SW, Calgary AB T2R 1J8 P403.530.0000 F403.265.5980 www.uthrive.ca

Last name: _____ First Name: _____

Address: _____Postal Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Birth date (dd/mm/yyyy)_____/_____/_____

Sex: M / F Height: _____ Weight: _____ Occupation: _____

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Who may we thank for your referral? _____

Reason for appointment: _____

When did your condition begin? _____

Have you had similar problems in the past? (circle one) YES NO

Have you had X-rays, MRI or other tests for this condition? What tests and when?

_____

Is this condition related to work? (circle one) YES NO

Has your employer been notified? (circle one) YES NO

Is this condition related to a motor vehicle accident? YES NO Date of injury: _____

Can you perform your daily home activities? _____YES _____YES, but only with help _____Not at all

Can you perform your daily work activities? _____ All activities _____ Some _____ Not at all

Describe your stress level: (circle one) NONE MILD MODERATE HIGH

Do you exercise? _____ Daily _____ Occasionally _____ Not at all

Please list any previous surgeries, illnesses, injuries (ex. Motor Vehicle Accident)

_____

_____

Family doctor name: _____ Phone #: _____

List all medications: _____

Emergency contact person: _____ Phone #: _____

Date: _____ Signature: _____

**PLEASE NOTE THAT NO SHOWS/LATE CANCELLATIONS (less than 24 hours) WILL BE CHARGED THE FULL TREATMENT FEE.**

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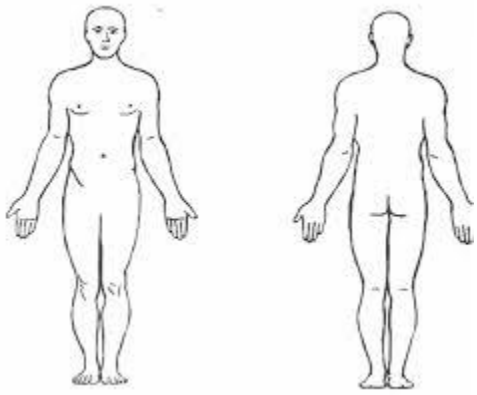
**Health History Questionnaire**

Have you ever been diagnosed or told you have any of the following?

Please circle the correct response.

1. Diabetes..... Yes No
2. Tuberculosis..... Yes No
3. Cancer, where?_____ Yes No
4. Heart or blood diseases ..... Yes No
5. Bone spurs in neck area (cervical sprain)..... Yes No
6. Whiplash injury (flexion-extention injury, cervical sprain)..... Yes No
7. Have you or any of your relatives suffered from a stroke? ..... Yes No
8. Are you a smoker? Or were you? From_____ to _____ Yes No
9. Slurred speech or other speech problems? ..... Yes No
10. Loss of consciousness, even momentary blackouts..... Yes No
11. Sudden collapse without loss of consciousness ..... Yes No

Indicate area and severity of pain by circling an area and a number



**0 1 2 3 4 5 6 7 8 9 10**

**No pain----------Extreme pain**

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# Systems Review

*Please check any conditions that are presently causing you a problem or have caused you problems in the past.*

## General Symptoms

- ☐ fever
- ☐ sweats
- ☐ fainting
- ☐ sleep disturbances
- ☐ fatigue
- ☐ nervousness
- ☐ weight loss
- ☐ weight gain

## Neurological

- ☐ visual disturbances
- ☐ dizziness
- ☐ fainting
- ☐ convulsions
- ☐ headache
- ☐ numbness
- ☐ neuralgia (nerve pain)
- ☐ poor coordination
- ☐ weakness

## EENT

- ☐ eye pain
- ☐ double vision
- ☐ ringing in ears
- ☐ deafness
- ☐ nosebleeds
- ☐ trouble swallowing
- ☐ hoarseness
- ☐ sinus infection
- ☐ nasal drainage
- ☐ enlarged glands

## Respiratory

- ☐ chronic cough
- ☐ spitting up phlegm
- ☐ spitting up blood
- ☐ chest pain
- ☐ wheezing
- ☐ difficulty breathing
- ☐ asthma

## Cardiovascular

- ☐ rapid heart rate
- ☐ slow heart rate
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ heart pain
- ☐ hardening arteries
- ☐ swollen ankles
- ☐ poor circulation
- ☐ palpitations
- ☐ cold hands and/or feet
- ☐ varicose veins

## Muscle & Joint

- ☐ neck pain
- ☐ low back pain
- ☐ arm pain
- ☐ shoulder pain
- ☐ leg pain
- ☐ knee pain
- ☐ foot pain
- ☐ pain/numbness
- ☐ pain between shoulders
- ☐ swollen joints
- ☐ spinal curvature
- ☐ arthritis
- ☐ fractures

## Genitourinary

- ☐ frequent urination
- ☐ painful urination
- ☐ blood in urine
- ☐ pus in urine
- ☐ kidney infection
- ☐ prostate trouble
- ☐ uncontrollable urine flow

## Gastrointestinal

- ☐ poor appetite
- ☐ difficult digestion
- ☐ heartburn
- ☐ ulcers
- ☐ nausea
- ☐ vomiting
- ☐ constipation
- ☐ diarrhea
- ☐ blood in stool
- ☐ gallbladder/jaundice
- ☐ colitis

## For WOMEN only

- ☐ painful menstruation
- ☐ hot flashes
- ☐ irregular cycle
- ☐ back pain
- ☐ vaginal discharge
- ☐ nipple discharge
- ☐ lumps in the breast
- ☐ menopausal
- ☐ birth control pills
- ☐ miscarriages
- ☐ pregnancy complications
- ☐ pregnancy, week? _____