# BURLINGTON PHYSIOTHREAPY & HEALTH CLINIC

2004 Caroline Street • Burlington, ON • L7R1K9 • Tel: (905) 333-1515

# Patient Intake

## PERSONAL INFORMATION

| TITLE: MR. ☐ MRS. ☐ MISS. ☐ MS. ☐ DR. ☐ | | | | DATE |
|---|---|---|---|---|
| FIRST NAME | INITIAL | LAST NAME | | OCCUPATION |
| ADDRESS | | CITY | PROVINCE | POSTAL CODE |
| HOME TELEPHONE | CELLULAR PHONE | BUSINESS PHONE | EMAIL ADDRESS | |
| BIRTH DATE DAY/MONTH/YEAR | SEX<br>☐ MALE ☐ FEMALE | HOW DID YOU HEAR ABOUT US? | | |

IN CASE OF EMERGENCY

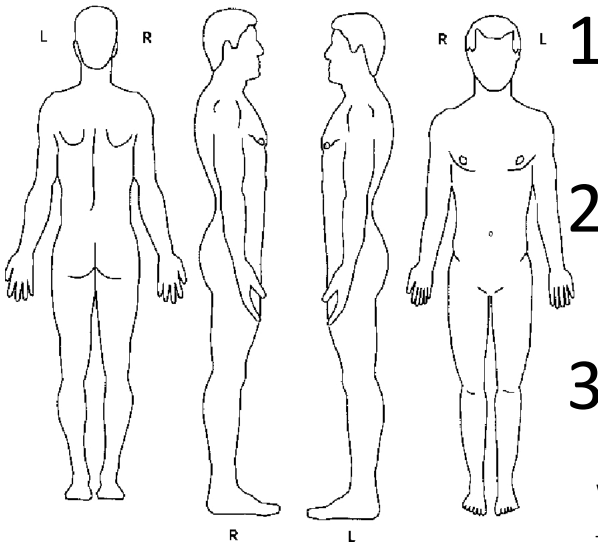
| CONTACT NAME | TELEPHONE | RELATIONSHIP |
|---|---|---|

## MEDICAL INFORMATION

DO YOU HAVE A MEDICAL DOCTOR? ☐ Yes ☐ No *IF YES, PLEAE COMPLETE THE FOLLOWING.*

| DOCTOR'S NAME | DOCTOR'S TELEPHONE NUMBER | | LAST VISIT |
|---|---|---|---|
| ADDRESS | CITY | PROVINCE | POSTAL CODE |
| DO YOU HAVE ANY ALLERGIES | ARE YOU MAKING A CLAIM FOR | 1) RECENT MOTOR VEHICLE ACCIDENT ☐ YES ☐ NO<br>2) WORK RELATED INJURY/ACCIDENT (WSIB) ☐ YES ☐ NO | |

## CHIEF COMPLAINT




1

2

3

**HOW TO COMPLETE THIS DIAGRAM**

On the body to the left, using the symbols below, please mark the location of your primary complaint and described sensation.

| Ache | Burning | Numbness | Tingling | Stabbing/Sharp | Deep |
|---|---|---|---|---|---|
| XXXX | ++++++ | ^^^^^ | ****** | ///////// | ====== |

How did your symptoms start?

- ☐ sudden
- ☐ gradual
- ☐ car accident
- ☐ work related injury

When did your symptoms start?

- ☐ 0-3 months ago
- ☐ 3-6 months ago
- ☐ 6-9 months ago
- ☐ 1 year or more ago

Please mark on the line below the level of your discomfort.

----------------------------------------------------------------------------------------------------------------

0 no pain — 10 worst pain

What is the reason for seeking care today? ____________________________________________

____________________________________________________________________________

Have you sought treatment from any other health care professional? ☐ YES ☐ NO

Treatment Received ____________________________________________________________

____________________________________________________________________________