



CLIENT INTAKE FORM

Name: _____ Phone: _____
Address: _____ Email Address: _____

Occupation: _____
Date of Birth: _____ Employer: _____
MM/DD/YYYY
Sex: Male Female
Family Doctor: _____
Doctor's address: _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____
Address: _____

Guardian Information (if under 21 years of age):

Name: _____ Phone: _____ Relationship: _____
Address: _____

Is your injury a Workplace safety and Insurance Board (WSIB) Claim? Yes No

Was your injury due to a Motor Vehicle Accident (MVA)? Yes No

Do you have Extended Health Care Benefits? Yes No

How did you hear about us? Doctor Internet Friends / Family
 Other: _____

Signature:

Date:

Health for life. Inside and Out.



PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____ **DOB:** _____

Age: _____ **Height:** _____ **Weight:** _____ **Occupation:** _____

What is the reason for your visit? _____

Do you currently have:

- Dizziness / fainting
- Seizures / epilepsy
- Night pain
- Numbness / weakness
- Shortness of breath
- Fever / chills
- Bowel / bladder control problems
- Numbness in the genital area
- Are you pregnant
- Poor circulation / bruising
- Artificial joints
- Unexplained muscle weakness
- Unexplained weight loss or gain
- Pacemaker

Have you ever had:

- Cancer
- Heart problems
- High blood pressure
- Joint Replacements
- Rheumatoid arthritis
- Tuberculosis / hepatitis / HIV
- Osteoporosis
- Asthma
- Stroke
- Chest pains
- Fainting / dizziness
- Pneumonia
- Mental illness
- Prolonged steroid use

Does your pain wake you up at night? Yes No

Do you smoke? Yes No

Have you had any imaging done?

X-ray MRI CT scan Other: _____

Do you have feelings of anxiety? Yes No

Do you have difficulty with depression? Yes No

Please list any medications you are on:

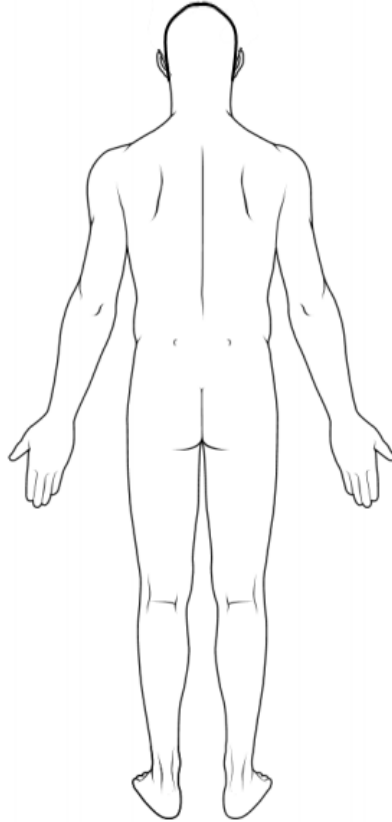
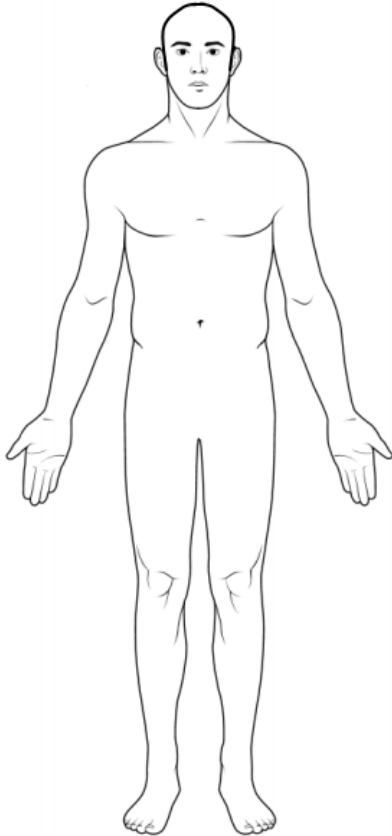
Is there any reason why you should not follow an activity / exercise program?

If yes, please explain:

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Please indicate where your area of concern is



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