NEUROFOCUS PHYSIOTHERAPY & SPORTS INJURY CLINIC

INTAKE FORM
Tel: 604-503-5343 Fax: 604-503-5373
info@neurofocusphysio.ca
www.neurofocusphysio.ca

PATIENT INFORMATION

Name: _____ Birthday (M/D/Y): _____ Age: _____ Gender: _____

Address: _____
(Street) (City) (Postal Code)

Home Ph. #: _____ Cell: _____ Email: _____

Care Card # : _____ Occupation:_____

Emergency Contact Name: _____Phone/Cell:_____

Name of Medical Doctor: _____ Phone:_____

How did you hear about this clinic: ☐ Friend/Family ☐ Internet ☐ Flyer

☐ Dr Referral: _____ ☐ drive by/sign ☐ Other:_____

MAIN CONCERNS

Please list, in order of importance, your chief concerns:

1. _____

2. _____

3. _____

PAST MEDICAL HISTORY

Please list if you have the following conditions:

High blood pressure:	Pacemaker:
Heart disease:	Arthritis:
Diabetes:	Allergies:
Eczema:	Asthma:
Cancer:	Dizziness/Vertigo:
Stroke:	Liver disease:
Thyroid disease:	Depression/Anxiety:
Metal implant:	HIV:

Please list hospitalizations, surgeries, major accidents/injuries, x-rays, CAT scans, MRIs, EKGs, etc.

Year: _____ Description: _____

Year: _____ Description: _____

Signature_____ Date: _____

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Please list all current medications. You can also provide a detailed list if available.

_____

_____

CURRENT CONDITION:

1. Please describe your current condition & Symptoms:

2. How long have you had this condition?

3. How did it start?

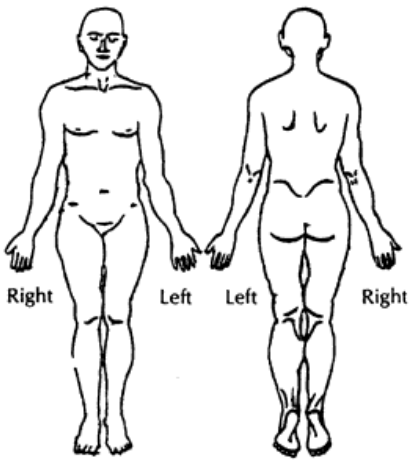
4. Is it getting better, worse or the same?

5. What aggravates it?

6. What relieves it?

7. **Do you have *pain*:** Please mark areas of pain on body and describe:
   _____
   _____

8. Please rate your current level of pain on the following scale (circle one):
   0 1 2 3 4 5 6 7 8 9 10
   (no pain) (worst imaginable pain)



Signature_____ Date: _____

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REHABILITATION PATIENTS ONLY

9. Date of Onset: _____/_____/_____

Diagnosis: _____ ☐ Stroke Side of Body affected: Right ☐ Left ☐

Date of Stroke: _____

Dominant Hand Prior to Stroke: Right ☐ Left ☐ Type of Stroke: _____

☐ Other Injury or Surgical Procedure: _____

ACTIVITIES OF DAILY LIVING

10. **Do you need assistance for any of the following activities?**

Getting in/out of bed Yes ☐ No ☐ Min Assistance ☐ Moderate ☐ Maximum ☐

Getting dressed/undressed Yes ☐ No ☐ Min Assistance ☐ Moderate ☐ Maximum ☐

Toileting Yes ☐ No ☐ Min Assistance ☐ Moderate ☐ Maximum ☐

Eating Yes ☐ No ☐ Min Assistance ☐ Moderate ☐ Maximum ☐

Showering/Bathing Yes ☐ No ☐ Min Assistance ☐ Moderate ☐ Maximum ☐

Walking Yes ☐ No ☐ Min Assistance ☐ Moderate ☐ Maximum ☐

Have you fallen in the past 6 months? Yes ☐ No ☐
If so when?

Pre-diagnosis recreation and hobbies: _____

Are you Currently Enrolled in Physical Therapy: Yes ☐ No ☐

If so, Where: _____

Signature_____ Date: _____