Life ’n Balance
WELLNESS CENTRE

Physiotherapy Intake Form

How did you hear about Life ‘n Balance? ____

Name: ________________________________ Gender: ____ Occupation: __________________________

Phone Number: ___________________ text reminders? □ Secondary Number: ______________________

Address: ____ Postal Code: _________________

Email: ____ Date of Birth: _____________________________

Alberta Health Care #: ______________________ Are you here for a WCB Case? ______ MVA Case? ______

Emergency Contact (name and number): ____

_ _

The following information will be used to help plan safe and effective physiotherapy treatment. Please answer the questions to the best of your knowledge.

1. What health goals would you like to achieve?

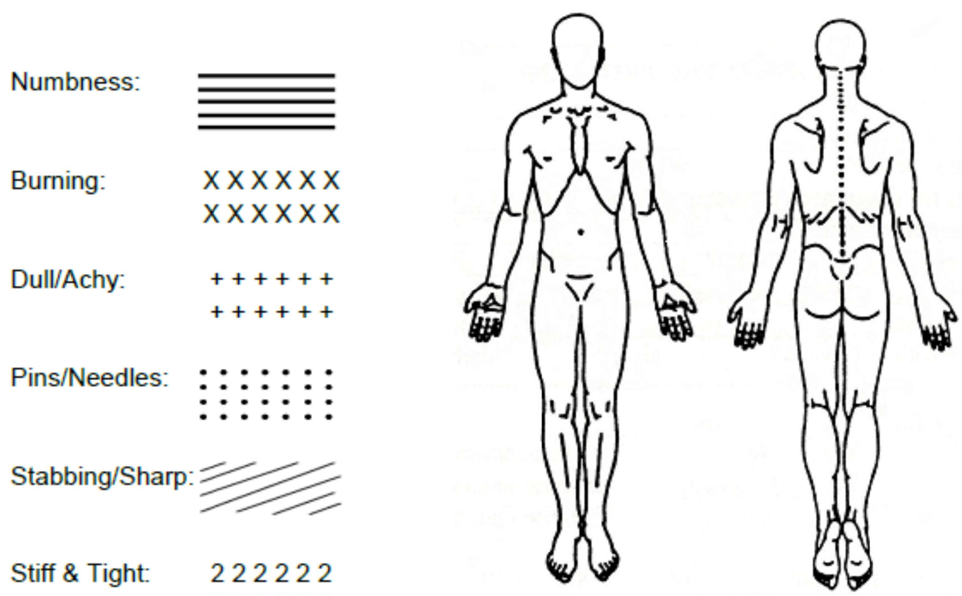
   □ Pain relief – Focus on relieving pain and control of symptoms

   □ Rehabilitation – Focus on restoring strength and function

   □ Prevention – Focus on avoiding pain episodes and injury

   □ Other - ____

2. Please indicate the area on the provided diagrams which best represents the pain(s) and or sensation(s) you are currently experiencing. Please include all areas and use the symbols provided below.



R Front L   L Back R

3. Have you visited a physiotherapist before? If yes, what area was treated? ___________________

   How were the results? Good □ Fair □ Poor □

Please Flip Over

4. Do you have a medical doctor? If yes, doctors name: _____
   Do you authorize Life 'n Balance to exchange medical information with your doctor? Yes □ No □

Please **circle** any conditions or symptoms which are **presently causing you problems.**

Please **check** any conditions or symptoms which have been **problems to you in the past.**

General
Osteoporosis
Loss of consciousness
Cancer/Previous Cancer
Headaches
Fevers
Sweats
Fainting
Dizziness
Clumsiness
Tremors
Loss of sleep
Numbness
Anxiety
Depression
Loss of weight

Muscle & Joints
Arthritis
Swollen joints
Diffuse muscle pain
Stiff joints
Back pain
Neck pain
Shoulder pain
Elbow pain
Wrist pain
Hip pain
Knee pain
Ankle/Foot pain

E.E.N.T
Frequent colds
Sinus infection
Asthma
Failing vision
Blurred vision
Double vision
Ear aches
Ringing/buzzing in ears
Deafness
Slurred speech
Difficulty swallowing
Nosebleeds
Enlarged glands
Enlarged thyroid

Respiratory
Chest pain
Chronic cough
Difficulty breathing
Spitting up blood
Spitting up phlegm

Cardiovascular
Heart disease
Stroke
Bleeding disorder
High blood pressure
Pain over heart
Hardening of arteries
Varicose veins
Swelling of ankles
Poor circulation
Heart murmur or arrhythmia

Gentourinary
Trouble urinating
Blood in urine
Kidney infection
Bed wetting
Prostate trouble
Frequent urinating

G.U. For Women
Painful menstruation
Excessive flow
Hot flashes
Irregular cycle
Cramps or backache
Discharge
Swollen breasts
Lumps in breasts

Have you ever been on birth control pills?
Yes □ No □

Are you currently taking birth control pills?
Yes □ No □

# of pregnancies: _____
# of children: _____

Skin
Rashes/Itching
Easy bruising
Dryness
Boils
Hives/Allergies

Gastrointestinal
Diabetes
Poor appetite
Indigestion
Excessive hunger
Belching or gas
Nausea
Vomiting
Pain over stomach
Constipation
Diarrhea
Hemorrhoids
Jaundice
Gall stones
Intestinal worms
Ulcers

Do you have a family history of
□ heart disease?
□ diabetes?
□ stroke?
□ cancer?

Do you currently smoke?
Yes □ No □
If no, did you smoke in the past?
Yes □ No □

Do you exercise?
Yes □ No □
If yes, how often? _____

Have you had any
□ fractures?
□ surgeries?
□ motor vehicle accidents?
□ hospitalizations?

Do you take any medications or supplements?
Yes □ No □

Do you have any other health concerns not listed? _____