Hands First
Physiotherapy

Intake Form

Name Date of Birth / /

Address

Contact Information

Phone

Email

Physician

Family Doctor

Address

Health Insurance (yes/no)

Insuring Company

Policy #

Identification #

Motor Vehicle Accident (MVA)

Insuring Company

Claim #

Date of Accident

Adjustor

Treatments will be explained by your physiotherapist. Make sure to ask questions if there is anything you don't understand. You have the right to refuse any treatment. Your chart may be randomly choosen for a quality assurance audit as is required by our licensing board.

Signature **Date** / /

We wish to send reports to your family doctor but require your permission. Will you permit us to do so? Please Initial . Are there any other proffessionals you would like to be sent copies?

How did you hear about our clinic?

Medical History (check all that apply)

- ◻ Motor Vehicle Accident
- ◻ Fractured Bone
- ◻ Sprains or Strains
- ◻ Osteoarthritis
- ◻ Rheumatoid Arthritis
- ◻ Bone Disease
- ◻ Lupus
- ◻ Eczema
- ◻ Headaches
- ◻ Metallic Implants
- ◻ Osteoporosis
- ◻ Scoliosis
- ◻ Heart condition
- ◻ Chest pain
- ◻ lymphedema
- ◻ High blood pressure
- ◻ Low Blood pressure
- ◻ Circulation problems
- ◻ Blood Clots
- ◻ Varicose Veins
- ◻ Bleeding disorder
- ◻ Bruise Easily
- ◻ Asthma
- ◻ Allergies
- ◻ Smoking
- ◻ COPD
- ◻ Angina
- ◻ Hepatitis
- ◻ Herpes
- ◻ TB
- ◻ HIV
- ◻ Neurological Disease
- ◻ Stroke
- ◻ Numbness or pain of genitals
- ◻ Heavy feet or difficulty Walking
- ◻ Falling for no reason
- ◻ Dizziness
- ◻ Difficulty speaking
- ◻ Difficulty swallowing
- ◻ Double Vision
- ◻ Tingling face/lips/tounge
- ◻ Epilepsy
- ◻ Unexplained Weight Loss
- ◻ Night sweats
- ◻ Unexplained loss of energy
- ◻ Cancer
- ◻ Previous bad reaction to physio/Chiro
- ◻ Mental Health Issues
- ◻ Nicotine
- ◻ Caffiene
- ◻ Poor Nutrition
- ◻ Sleep disorder
- ◻ IBS
- ◻ Diariaha
- ◻ Constipation
- ◻ GERD/Reflux
- ◻ Pregnant (or trying)
- ◻ Diabetes
- ◻ Thyroid Disorder
- ◻ Fibromyalgia

Date / / **Signature** **PT Signature**