physiomobility HEALTH GROUP

Patient ID: _____

GENERAL PATIENT INTAKE FORM

PERSONAL INFORMATION

_____ _____ _____
First Name *Last Name and Middle Initial* *Date of Birth (D/M/Y)*

_____ _____ _____ _____
Street Address & Number City Province Postal code

_____ _____ _____
Home Phone Number *Work Phone Number* *Cell Phone Number*

Physiomobility Health Group staff may leave phone messages at provided numbers for confirmation or changes to your scheduled appointments.
(Please inform our administration staff if you do not want us to leave phone messages)

_____
Email address

(By providing your email, you are consenting to email communication from Physiomobility Health Group clinics such as appointment reminders, statements, invoices, exercise instructions, newsletters & commercial electronic messages).

_____ _____
Family Physician's Name *Family Physician's Phone Number*

Referred by: ☐ Doctor ☐ Family/Friend/Patient ☐ Internet ☐ Flyer
☐ TTC Ad ☐ Event_____ ☐ Other _____

EMERGENCY CONTACT

_____ _____
Contact Name *Phone Number*

Have you been injured at work? ☐ Yes ☐ No **Is this a WSIB claim?** ☐ Yes ☐ No

Have you been injured in a car accident? ☐ Yes ☐ No **Is this an MVA claim?** ☐ Yes ☐ No

(If your answer is Yes to any of the above, additional information is required)

_____

_____

_____

☐ ***Physiomobility*** DON MILLS
6 Maginn Mews, Suite 211
Shops at Don Mills
Tel: 416-444-4800
Fax: 416-444-4811

☐ ***Physiomobility*** THORNHILL
8150 Yonge St. Suite 1
Yonge & Uplands
Tel: 905-731-6777
Fax: 905-731-3336

☐ ***Physiomobility***
HOME HEALTHCARE
Central & North GTA
Tel: 416-444-9547
Fax: 416-444-4811

☐ ***Pain Management***
& Fibromyalgia Centre
6 Maginn Mews, Suite 211-A
Tel: 416-444-0699
Fax: 416-444-4811

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HEALTH SCREENING QUESTIONNAIRE

The health information requested on the following form will assist us in treating you safely. If you have any questions about the requested information, please feel free to ask.

Primary reason for your visit? _____

Do you currently have or have previously had any of the following conditions?

- ☐ Diabetes
- ☐ Gynaecological Conditions
- ☐ Cancer
- ☐ Stroke/CVA
- ☐ Hepatitis
- ☐ Broken Bone
- ☐ Epilepsy Other
- ☐ Kidney Problems _____
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Allergies
- ☐ Thyroid Problems
- ☐ Arthritis
- ☐ Lung Conditions
- ☐ HIV/AIDS
- ☐ Skin Conditions
- ☐ Heart Disease _____
- ☐ Other _____

Current Medications:

_____ _____
_____ _____
_____ _____
_____ _____

For Women:

1. Do you have any children? ☐ Yes ☐ No
2. Have you had a C-Section? ☐ Yes ☐ No
3. Are you currently pregnant? ☐ Yes ☐ No

Have you had any surgeries? Please provide details:

_____

_____

Do you currently (or within the past year) have any of the following symptoms?

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Difficulty Swallowing
- ☐ Unexplained Weight Change
- ☐ Loss of Appetite
- ☐ Fevers/Chills/Sweats
- ☐ Unrelenting Night Pain
- ☐ Urinary/Bowel Problems
- ☐ Metal implant
- ☐ Depression
- ☐ Heart Palpitations
- ☐ Headache/ Migraines
- ☐ Loss of Balance/Co-ordination
- ☐ Speech Disturbances
- ☐ Dizziness/Blackouts
- ☐ Numbness in any part of your Body
- ☐ Weakness in Arms and Legs
- ☐ Seizures
- ☐ Pacemaker
- ☐ Anxiety

Please tell us what your three (3) primary goals are or what you wish to achieve at Physiomobility?

1. _____
2. _____
3. _____

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