DAVID BRALEY SPORT MEDICINE AND REHABILITATION CENTRE

PHYSIOTHERAPY INITIAL INTAKE FORM

NAME:		DATE:
ADDRESS:		
CITY:	PROVINCE:	POSTAL CODE:
NAME OF FAMILY PHYSICIAN (MD):		
HOME PHONE:	CELL PHONE:	WORK PHONE:
DATE OF BIRTH:	OCCUPATION:	EMPLOYER:
HOW DID YOU HEAR ABOUT OUR CLINIC?		
ARE YOU HERE AS A RESULT OF A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO		
EMAIL:	McMASTER STUDENT NUMBER:	

HISTORY OF PRESENT CONDITION

DESCRIBE YOUR MAJOR COMPLAINTS:

HAVE YOU EVER RECEIVED ANY FORM OF TREATMENT FOR YOUR CONDITION?
☐ YES ☐ NO IF YES, WHAT TYPE? ____________________

HAVE YOU OBTAINED X-RAYS, MRI, EMG, CT SCANS OR LAB WORK?
☐ YES ☐ NO IF YES, WHICH?____________________ WHERE? ____________________

PAST HEALTH HISTORY

HAVE YOU ….	YES	NO	IF YES PLEASE EXPLAIN….
HAVE YOU BEEN HOSPITALIZED IN THE LAST 5 YEARS?			
HAD ANY SURGERIES?			
SUFFERED ANY MAJOR PHYSICAL TRAUMA?			
SUFFERED ANY BROKEN BONES?			

FOR EACH OF THE CONDITIONS LISTED BELOW, PLEASE PLACE A CHECK IF YOU ARE, OR HAVE IN THE PAST EXPERIENCED ANY OF THE FOLLOWING:

	HEADACHES		HEART ATTACK		EXCESSIVE THIRST
	NECK PAIN		CHEST PAIN		FREQUENT URINATION
	UPPER BACK PAIN		STROKE		CHRONIC SINUSITIS
	MID BACK PAIN		ANGINA		SMOKING/TOBACCO USE
	LOWER BACK PAIN		KIDNEY STONES		DRUG/ACOHOL DEPENDANCE
	SCIATICA		KIDNEY DISORDERS		ALLERGIES
	SHOULDER PAIN		BLADDER INFECTION		DEPRESSION
	ELBOW OR UPPER ARM PAIN		PAINFUL URINATION		SYSTEMIC LUPUS
	WRIST PAIN		LOSS BOWEL/BLADDER CONTROL		EPILEPSY
	HAND PAIN		PROSTATE PROBLEMS		DERMATITIS/ECZEMA/RASH
	ANKLE/FOOT PAIN		ABNORMAL WEIGHT LOSS/GAIN		HIV/AIDS
	JAW PAIN		DIMINISHED APPETITE		VISUAL DISTURBANCES
	JOINT SWELLING OR STIFFNESS		ABDOMINAL PAIN		DIZZINESS
	ARTHRITIS		ULCER		BIRTH CONTROL PILLS
	RHEUMATOID ARTHRITIS		HEPATITIS		PREGNANCY
	GENERAL FATIGUE		LIVER/GALL BLADDER DISORDER		HORMONAL REPLACEMENT
	FIBROMYALGIA		CANCER TYPE:		***OTHER HEALTH ISSUES:***
	HEART ARRYTHMIAS		TUMOR		
	PACE MAKER		OSTEOPOROSIS		
	ASTHMA		DIABETES		
	ANUERYSM		HIGH BLOOD PRESSURE		

FAMILY HISTORY: IF ANY BLOOD RELATIVE HAS ANY OF THE FOLLOWING CONDITIONS, PLEASE CHECK AND INDICATE:

	ANEMIA		DIABETES		HIGH BLOOD PRESSURE
	ATHEROSCLEROSIS		DISC DISORDER		HIGH CHOLESTEROL
	ARTHRITIS		EMPHYSEMA		MULTIPLE SCLEROSIS
	ASTHMA		EPILEPSY		OSTEOPOROSIS
	BACK ACHE		GLAUCOMA		PINCHED NERVE
	BLEED EASY		HEADACHES		STROKE
	CANCER		HEART TROUBLE		THYROID DISEASE

MEDICATIONS: PLEASE LIST ANY MEDICATION YOU ARE CURRENTLY TAKING AND WHY

TYPE	PURPOSE
PLEASE INDICATE ANY OTHER INFORMATION THAT MAY BE RELEVANT TO YOUR CONDITION:	

ALLERGIES: PLEASE LIST ALL ALLERGIES OR SENSITIVITIES:

PLEASE COMPLETE THE FOLLOWING "PAIN DIAGRAM" BY USING THE LETTER TO INDICATE YOUR AREAS OF PAIN:

PAIN (P); TINGLING (T); NUMBNESS (N); BURNING (B); STIFFNESS (S)