

Please print clearly. If you have any questions, please do not hesitate to ask! Thank You.

Mr/Mrs/Ms *Last Name:	*First Name:		
*Address:			
	*Postal Code:		
*Email:			
	Cell Phone#:		
*Birth date: M/D/ Gender: N	Male/Female Occupation:		
Family Doctor:	phone #:		
*How did you hear about us?	·		
*Reason for visiting Physio Village Clinic to	oday:		
Please list the healthcare services you are o	currently receiving:		
□Physiotherapy □Chiro □ Massage	☐ Acupuncture ☐ Osteopathy ☐Other		
Emergency Contact Information:			
Emergency Contact:	Relationship:		
Email:	Phone#:		
Insurance Coverage: ☐ Yes ☐ No Co	ompany:		
*Have you taken any anti-inflammatory me relaxants or mood altering medication with	edication, painkillers (including aspirin, Advil etc.), muscle nin the past two hours?		
If yes, what and how much?			
Surgeries: (include year and type of surgery	<i>(</i>)		
Accidents:			
Allergies:			
Medications (please provide name and dos	age):		
Family Medical History			



PATIENT INTAKE FORM

In the past month, have you had any of the following problems?			
GENERAL	NERVOUS SYSTEM	PSYCHIATRIC	
☐ Recent weight loss/ gain; how much	☐ Stroke (CVA)	☐ Depression	
☐ Fatigue, Weakness ,Fever ,Night sweats	□ Concussion	☐ Excessive worries	
☐ Diabetes	☐ Fainting or loss of consciousness	☐ Difficulty falling asleep	
☐ High Cholesterol	■ Numbness or tingling	☐ Difficulty staying asleep	
☐ Cancer history	☐ Memory loss	☐ Difficulties with sexual arousal	
☐ HIV/AIDS/Hepatitis	□ Epilepsy	☐ Poor appetite	
MUSCLE/JOINTS/BONES	STOMACH AND INTESTINES	☐ Frequent crying	
■ Numbness	☐ Nausea	☐ Sensitivity	
☐ Joint pain	☐ Heartburn	☐ Thoughts of suicide / attempts	
☐ Muscle weakness	☐ Stomach pain	HEART AND LUNGS	
☐ Joint swelling	☐ Vomiting	☐ Chest pain, Palpitations, Fainting	
Where?	☐ Yellow jaundice	☐ High/Low Blood Pressure	
EARS	☐ Persistent diarrhea	☐ Chronic Cough	
☐ Ringing in ears	☐ Blood in stools	Asthma, Bronchitis, Emphysema	
☐ Loss of hearing	☐ Black stools	☐ Heart Attack/ Heart Failure	
EYES	SKIN	☐ Stroke	
☐ Pain/ Redness/ Dryness	☐ Redness/Rash/Bumps	KIDNEY/URINE/BLADDER	
☐ Loss of vision	Color changes of hands or feet	☐ Frequent or painful urination	
■ Double or blurred vision	☐ Infectious conditions	☐ Blood in urine	
THROAT	Other:		
☐ Frequent sore throats			
☐ Difficulty in swallowing			

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please be sure to let us know. This form must be updated annually. All information gathered for this treatment is confidential and will be released to other health care professionals or legal representatives only upon your written consent. Information may be shared with your other health care practitioners here at "Physio Village Clinic Inc." in order to maximize your health care goals. Please inform us if you do not wish for that to occur. Please be aware that you may request to stop or alter the treatment at any time for any reason and the therapist will comply with your wishes. Although the utmost care will be taken to ensure safety and comfort for the patients, in the event of injury, our clinic, Physio Village Clinic Inc. will not be held liable for any reason.

<u>Refund and Cancellation Policy</u>: Please note that **24 hours advance notice is required for cancellation of all appointments**; otherwise you will be charged **\$50.00 for the missed visit.**

- I have read and understand the above and give my consent to be assessed & receive treatment and services provided by Physio Village Clinic Inc. By signing this section, I am subscribing to Physio Village Clinic Inc. newsletters & promotions. Additionally, I consent to pictures and videos to be taken of me at Physio Village Clinic. I understand that these pictures may be used in various marketing and social media only upon my written consent.

Name Signature Date