BACK & BODY HEALTH

CALGARY MASSAGE CLINIC

PHYSIOTHERAPY INTAKE FORM

PERSONAL INFORMATION		
Name:		Today's Date (mm/dd/yyyy):
Date of birth (mm/dd/yyyy)	Age:	Gender:
Address		
City:	Province:	Postal Code:
Home/Cell Phone:	Work Phone:	
Your occupation:	Employer:	
E-mail address:		
Permission for correspondence through	❑ Phone ❑ Mail ❑ Occasion cards ❑ E-mail ❑ Other:	

In case of emergency, whom should we notify?	
Relation to you:	Contact number:

Alberta Health Care Number:	Family Doctor:
Extended Health Care Company:	

How did you hear about our office	❑ Health Care Prof. ❑ Friend ❑ Sign ❑ Internet ❑ Other: _______
If you checked friend who can we thank:	

REASON FOR APPOINTMENT
What is your chief complaint?
Describe the onset
Provide the primary symptoms. Rate the symptoms mild, moderate or severe

Using an "X", please rate your pain on the line below

No Pain ____Very Painful

1 5 10

Is this a car accident case	❑ Yes ❑ No	Have you recently been in an accident	❑ Yes ❑ No
***** If YES, please fill out Notice of loss & Proof of Claim (form AB-1) and MVA form *****			

Have you seen any other physician or health care professional for this complaint ❑ Yes ❑ No	
If YES, Doctors Name:	Date of last treatment:
Diagnosis:	What type of treatment did you receive:

Were you medically cleared for treatment? ❑ Yes ❑ No
List current medications, including aspirin, ibuprofen, antihistamines, birth control etc. and their purpose:
Do you suffer from headaches: ❑ Yes ❑ No If yes how often?
How long do they last?

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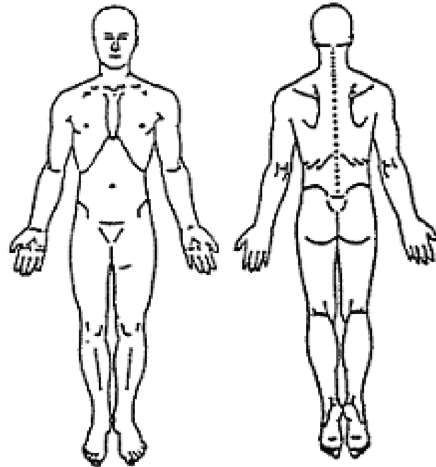
Mark the area(s) of pain or unusual feeling using the appropriate symbols.
▪ Circles area of PAIN
▪ "X" over the areas of JOINT AND MUSCLE STIFFNESS
▪ Draw squiggly lines along the areas of NUMBNESS, TINGLING OR ALTERED SENSATION
▪ Additional comments:



Surgery / Injury: Accidents: Other Medical Conditions:

WAIVER:
I have stated all medical conditions that I am aware of and will update the Physiotherapist of any changes in health status. I agree to immediately inform the therapist if I experience any pain of discomfort during my massage so that the pressure and / or strokes may be adjusted to my level of comfort. I also agree to request the Physio Therapist to stop treatment if I feel like my well-being is being compromised in any way. I assume all risks and responsibilities for myself and release the Physiotherapist and Back & Body Health from responsibility from any injury or liability that may occur during a treatment session. I consent to Physiotherapy treatment.

Signature	Date