Date: _____

CONFIDENTIAL INTAKE FORM

PERSONAL INFORMATION:

Last name _____ First name _____
Address _____ City _____
Prov._____Postal_____
Telephone number (home)_____ work or cell _____
Email _____
Card Card _____
Birth date (month/day/year) _____
Occupation _____ Sport _____
Who referred you for Athletic Therapy? _____
Name of family medical doctor? _____

HEALTH INFORMATION:

What is the main reason for your visit? _____
Area(s) of concern? _____
Date of injury? _____
Where did the injury occur? ___ Sport/leisure ___ Work ___Motor vehicle accident
ICBC____ WCB _____
Is it getting: ___better ___worse ___constant ___ comes and goes ___
Is this condition interfering with ___work ___ sleep ___daily routine ___other
_____
Have you had this condition in the past? ____ If yes, was it resolved? _____
Other treatment for condition : _____
Medications you are currently taking: _____

HEALTH HISTORY:

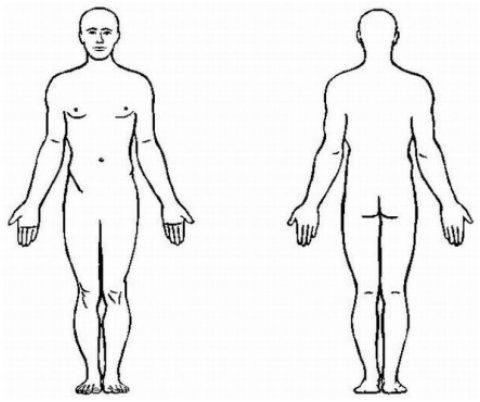
Please circle "Yes" or"No" for the following questions even if you do not think they are related to your health problem.
Have you suffered from:
1. Dizziness Yes or No
2. Heart trouble Yes or No
3. Chest pain brought on by activity Yes or No
4. Diabetes Yes or No
5. Arthritis Yes or No
6. Asthma Yes or No

7. Cancer Yes or No
8. Numbness and/or tingling Yes or No
9. High blood pressure Yes or No
10.Any past surgeries Yes or No
If yes, describe and date: _____
Any past injuries or medical conditions that may be affected by exercise? Yes or No
If yes, describe

_____

_____

DIAGRAM- mark where symptoms are



SYMPTOMS: check box
Pain ☐
Change in sensation (loss/increased): ☐
Heat: ☐
Locking/clicking: ☐
Feeling of instability: ☐
Audible noises: ☐

Explain: _____
_____
_____

VAS: Intensity of Pain

0 10
None As bad as it could possibly get

Circle the words that best describe your pain:

Sharp Dull Achy Tingling Numb Burning Constant Throbbing

Does your pain radiate? Yes No

Have you had any diagnostic testing done (i.e. x-rays, etc.)? _____

What makes the pain worse or brings on your pain? _____

What relieves your pain? _____

POLICIES AND INFORMED CONSENT

The fee or an initial assessment is $70.00 + hst. Athletic Therapy is not covered by MSP or WCB, please check with your personal insurance for coverage.

The fee for missed appointments, or cancellations without 12 hours notice will be $30.00. The fee will be due upon the following visit.

I hereby consent to Athletic Therapy treatments including the use of exercise prescription, electrical modalities and manual therapy techniques.

I understand that there may be some discomfort from the rehabilitation depending on the injury and I agree to inform the therapist should any additional symptoms occur. I understand that all exercise programs place a workload on the body to promote improvement and at the same time present the risk of negative body response to that exercise. I understand that the therapist will do their best care to properly progress, monitor and care for my injuries.

_____

Print Name

_____ _____

Signature of Patient or Parent/Guardian Date

888 Short St Victoria BC V8X 2V5 T: 250 477-5776 F: 250 477-5796 info@totalbodychiropractic.ca

TOTAL BODY CHIROPRACTIC AND SPORTS THERAPY

For Therapists Use:

Joint	Active		Passive		Resistive	
	Left	Right	Left	Right	Left	Right

Observations/Gait:

R/O: Above: +ve / -ve

Below: +ve / -ve

Capsular Patern:

Special Tests:

Palpations:

Assessment:

Plan:

Recommendations:

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