Premier Care Physiotherapy

11685 Yonge St. Unit A106
Richmond Hill, ON L4E 0K7

Tel: 905-237-7174
Fax:905-237-7184

GENERAL PATIENT INTAKE

PERSONAL INFORMATION:

First Name	Last Name and Middle Initial	Date of Birth (DD/MM/YYYY)

Street Address and Number	City	Province	Postal Code

Home Phone Number	Work Phone Number	Cell Phone Number

Premier Care Physiotherapy staff may leave phone messages at provided numbers for confirmation or changes to your scheduled appointments.

☐ DO NOT LEAVE PHONE MESSAGES

Email address: _____

(By providing your email, you are consenting to email communication from Premier Care Physiotherapy such as appointment reminders, statements, invoices, exercise instructions & commercial electronic messages).

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

Referred by:

☐Doctor ☐Family/Friend/Patient ☐Event _____

☐Flyer ☐Internet ☐Other _____

EMERGENCY 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 a MVA claim? ☐Yes ☐No

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

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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?

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

Current Medications

_____ _____
_____ _____
_____ _____
_____ _____

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 Premier Care Physiotherapy?

1) _____
2) _____
3) _____

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