Premier Care Physiotherapy

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

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

GENERAL INTAKE FORM

PERSONAL INFORMATION:

First Name _____ Last Name _____ Date of Birth (DD/MM/YYYY) _____

Street Address and Number _____ City _____ Province _____ Postal Code _____

Home 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 & promotional messages. If you wish not to receive promotional communications, please inform us.

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

Referred by: ☐ Doctor ☐ Family/Friend ☐ Events
☐ Social Media ☐ Internet ☐ Work

EMERGENCY CONTACT:

Name: _____ Phone Number: _____

Cancellation Policy:

We require a **minimum of 24 hours' notice** for change or cancellation of an appointment. This will allow us to fill the available time slot with another patient who needs our services. Your account will be charged the full treatment fee if you cancel with less than 24 hours' notice or if you do not show up for your appointment.

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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	☐ HIV/AIDS	☐ Shortness of Breath
☐ Cancer	☐ Lung Conditions	☐ Unrelenting Night Pain
☐Diabetes	☐ Osteoporosis	☐ Difficulty Swallowing
☐ Seizures	☐ Stroke/CVA	☐ Loss of Balance/Co-ordination
☐ Metal implant	☐ Heart Disease	☐ Unexplained Weight Change

Medications List: **Prescribed For:**

_____ _____

_____ _____

_____ _____

Have you had any surgeries? Please provide details:

_____

_____

Please tell us what your primary goals are or what you wish to achieve at Premier Care Physiotherapy?

_____

_____

_____

Only Fill Out 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