Hawthorn
NATUROPATHY • ACUPUNCTURE • MASSAGE THERAPY

PHYSIOTHERAPY INTAKE FORM

Welcome!

Our intake forms are quite extensive. Be prepared to answer a lot of questions!
This is a confidential record of your medical history and will be kept in this office.
Information contained here will not be released without your consent.

Full Name: ______________________________ Date of Birth: ________________________

Address: ____

Phone numbers: (home) ______________________ (mobile) _________________________

Email address: _______________________________ Occupation: _____________________

Emergency contact's name and relationship to you: _______________________________

Emergency contact's phone number: ____

Family doctor: ______________________ Referred by: ______________________________

Insurance Provider: _________________ Policy #:_______________ ID#: _______________

Reason(s) for seeking physiotherapy:

General Medical History:

Do any of the following health concerns/conditions/diagnoses apply to you?

Cardiac (heart) condition ☐
Diabetes ☐
Cancer (past or present) ☐
Rheumatoid arthritis ☐
Metal implants/screws/plates ☐
Epilepsy or other seizure disorder ☐
Pulmonary (lung) condition ☐
Multiple sclerosis ☐
Circulatory problems ☐
Pacemaker ☐
Pregnancy ☐
Circulation problems or blood clots ☐

If you have checked off any above conditions, please provide details here (if applicable):

Other medical conditions not listed above (please describe):

Surgical procedures:

Do you smoke? **Y** **N**

Allergies? **Y** **N**

Patient name: Date:

Current medications (please list all prescription and over-the-counter medications including supplements):

Pelvic Floor Therapy Questionnaire:

Number of pregnancies: Number of vaginal deliveries:

Number of caesarean deliveries: Year of last delivery:

Largest birth weight: Trouble healing post-delivery? **Y N**

Do you have regular periods? **Y N** Do you have frequent yeast infections? **Y N**

Do you have frequent urinary tract infections? **Y N**

Are you sexually active? **Y N**

Do you currently have a sexually transmitted infection? **Y N**

Do you have pain with (check all that apply):

Sexual intercourse ☐
Tampon use ☐
Pelvic exam ☐
Back, leg, groin, abdominal pain ☐

Have you had any of the following tests?

Urodynamic test Y N Results: ________________________________

Cystoscope Y N Results: ________________________________

Urine test Y N Results: ________________________________

Bowel test Y N Results: ________________________________

Do you leak urine when you:

Cough/sneeze/laugh ☐
Lift/exercise/dance/jump ☐
On the way to the bathroom ☐
Hear running water ☐
Have a strong urge to urinate ☐
Other______________________________

Do you:

Wet the bed ☐
Feel unable to empty bladder ☐
Have pain with urination ☐
Have pressure/"falling out" feeling ☐
Strain to start urination ☐
Urinate frequently ☐
Strain with bowel movement ☐
Leak/stain feces ☐
Leak gas by accident ☐
Have pain with bowel movement ☐
Have diarrhea often ☐
Take laxatives/ enema regularly ☐

How often do you move your bowels? ___________________________________

Thank you for taking the time to complete this questionnaire.