BEST HEALTH PHYSIO
Knowledge in motion

Intake Form

Date: ____ ____ ____
Year Month Day

Name: _____ Date of Birth: ____ ____ ____
Year Month Day

Address: _____

Contact Phone Number (Home, Cell or Work): _____

Email Address: _____

Family Physician: _____ Referring Practitioner: _____

Insurance Company, Policy Number: _____

Health Card Number: _____

Medical History

Please indicate if you have a history of any of the conditions listed below:

1. Seizure Disorder Yes ☐ No ☐

2. Arrhythmia Yes ☐ No ☐

3. Cardiac Rhythm Device Yes ☐ No ☐

4. Spinal Stimulator/Cochlear Implant Yes ☐ No ☐

5. Diabetes Yes ☐ No ☐

6. Cardiac History Yes ☐ No ☐

7. High Blood Pressure Yes ☐ No ☐

8. Circulatory Disorder Yes ☐ No ☐

9. Unexplained Weight Loss Yes ☐ No ☐

10. Recent Fever/Infection Yes ☐ No ☐

Continued ▸

2-1329 Gardiners Road, Kingston Ontario K7P 0L8, **T** 613.634.2378, **F** 613.634.2372, **W** besthealthphysio.ca

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11. Arthritis: Rheumatoid/Osteo/Other Yes ☐ No ☐

12. Bone Density: Osteopenia/Osteoporosis Yes ☐ No ☐

13. Surgery - Significant/Major Yes ☐ No ☐

14. Metal or Plastic Implants Yes ☐ No ☐

15. Infectious Diseases Yes ☐ No ☐

16. Cancer Yes ☐ No ☐

17. Receiving Other Care for Condition Yes ☐ No ☐

18. Recent Workplace or Motor Vehicle Injury Yes ☐ No ☐

19. Relevant Imaging: Xray/MRI/CT/Ultrasound Yes ☐ No ☐

20. Currently Taking Anticoagulants Yes ☐ No ☐

21. History of Taking Oral Steroids Yes ☐ No ☐

22. Pregnancy Yes ☐ No ☐

23. Other General Health Concerns/Conditions Yes ☐ No ☐

24. Current Medication List: _____

Other: _____

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