FALL RIVER
COLLABORATIVE HEALTH CARE

Physiotherapy Intake Initial

Personal Information

Name: _____
Last Name First Name Middle Initial Pronouns (He/She/They)

DOB: _____
Year Month Day

Address: _____
Street City Postal Code

Phone Number: _____
Home Cell Work

Email Address: _____

Occupation: _____ Employer: _____

Medical Doctor: _____ Health Card Number: _____

Emergency Contact (Name and Number) _____

How did you hear about our office?
( ) Patient Referral ( ) Road sign ( ) Google Search ( ) Social Media ( ) Another Practitioner ( ) Other

If other, tell us how! _____

Are you currently seeing any of the following:
( ) Massage Therapy
( ) Acupuncturist
( ) Chiropractor
( ) Osteopath
( ) Naturopathic Doctor
( ) Personal trainer
( ) Other Specialist

If Other, who?_____

Was this injury due to a car accident?
( ) Yes a new accident
( ) Yes, an old accident
( ) No

If Yes, is there an active insurance claim?
( ) Yes
( ) No
( ) Not yet

If Yes, please provide insurance details (Claim #, Policy #, Insurance company and adjusters name and contact)

_____

Is this a work related injury?
( ) Yes
( ) No
( ) Maybe

If yes or maybe, please provide details

_____

Is there an open WCB case? (please note, we are NOT WCB providers)
( ) Yes
( ) No

Health Status

Let us know what brought you into our office today:

What is the main reason for your visit today?
( ) New pain, injury or symptom
( ) Chronic Pain/ Flare of previous injury
( ) Maintenance care of a chronic condition
( ) Other

What area of your body is bothering you today?

_____

Have you had treatment for this condition?
( ) Yes
( ) No
( ) In past

If yes, or in past, please explain:

_____

If in past, how long ago? _____

If Other, please explain_____

FALL RIVER
COLLABORATIVE HEALTH CARE

Physiotherapy History

Have you ever seen a physiotherapist before?
( ) Yes
( ) No

If yes, How long has it been since you were treated?_____

General Health

This section gives us a better picture of your overall health and may help us with our diagnosis and/or recommendations.

Have you had any of the following test for the condition that you are experiencing
( ) X-ray
( ) CT
( ) EMG/Nerve conduction
( ) MRI
( ) Bone Density
( ) Ultrasound
( ) No imaging

Please list any results:

_____

List any current Medications (Including birth control and supplements) and doses if possible:

_____

Injections into any joints?
( ) yes
( ) no

If yes, please give details and dates.
_____

Do you exercise?
( ) No ( ) 1-2x per week ( ) 3-5x per week ( ) >5x
If yes, please explain_____

FALL RIVER
COLLABORATIVE HEALTH CARE

Have you had any Surgeries or hospitalizations?
( ) Yes
( ) No

Have you ever had any fractures or dislocations?
( ) Yes
( ) No
( ) Unknown

If yes, where? Please list all.
_____

Please explain any other health conditions you have:
_____

Check if you have had any of the following:

Neuromuscular skeletal
( ) Headaches ( ) Grinding/clenching teeth ( ) Stiff neck ( ) Upper back pain ( ) lower back pain
( ) Swollen joints ( ) Numbness ( ) Tremors ( ) Scoliosis ( ) Osteo Arthritis ( ) Rheumatoid Arthritis
( ) Psoriatic Arthritis ( ) Osteoporosis ( ) Carpal Tunnel ( ) Other

If other, explain: _____

Skin/Allergies
( ) Allergies ( ) Bruise easily ( ) Psoriasis ( ) Eczema ( ) Rashes or irritation ( ) Shingles
( ) Fungal Infection ( ) Skin sensitivities

Cardiovascular
( ) Heart Attack ( ) High Blood Pressure ( ) Low Blood Pressure ( ) High cholesterol ( ) Angina ( ) Stroke
( ) TIA ( ) Blood clots ( ) Varicose veins ( ) Irregular Heart beat/murmur
( ) Bypass Surgery ( ) Clotting issues ( ) Hemophilia ( ) Pacemaker ( ) Other

If other, explain: _____

Respiratory
( ) Asthma ( ) COPD ( ) Emphysema ( ) Difficulty breathing ( ) Chronic cough ( ) Chest pain
( ) Wheezing ( ) Other

If other, explain: _____

FALL RIVER
COLLABORATIVE HEALTH CARE

Digestive
( ) IBS ( ) Crohn's ( ) Colitis ( ) Diverticulitis ( ) Reflux ( ) Ulcers ( ) Food sensitivities ( ) Celiac ( ) Hernia
( ) Gall Stones ( ) Constipation ( ) Gas or bloating issues ( ) Diarrhea ( ) Nausea/vomiting ( ) Other

If other, explain: _____

Mental Health
( ) Depression ( ) Anxiety ( ) OCD ( ) Seasonal Affective disorder ( ) Personality Disorder ( ) Suicidal
( ) Schizophrenic ( ) Other

If other, explain: _____

Neurological
( ) Dizziness ( ) Loss of consciousness ( ) Vertigo ( ) Concussions ( ) Stroke ( ) TIA
( ) Visual disturbance ( ) Twitching ( ) Balance issues/clumsiness ( ) Speech difficulties ( ) Tremors
( ) Fainting ( ) Paralysis ( ) Bells palsy ( ) Multiple Sclerosis ( ) Seizures ( ) Other

If Yes to concussions, how many and when?_____
If other, explain: _____

Other
( ) Diabetes ( ) Allergies ( ) Loss of hearing ( ) Thyroid Issues ( ) Pregnant ( ) C-section ( ) HIV Positive
( ) Other STD ( ) Alcoholism ( ) Drug Addiction ( ) Fibromyalgia ( ) Chronic Fatigue Syndrome
( ) Chronic Pain Syndrome

Please tell us about anything that you feel we need to know regarding your health that we may have missed

_____
_____

Privacy Policy

We are committed to protecting the privacy of all individuals providing personal and medical information to us, including the data recorded by our patients in our system. Your information is stored on a remote server specifically protected for medical records. Your information entered is shared only with the clinic and medical information is kept confidential. Medical information is only visible to the practitioners of the clinic. Personal information will be entered into our system strictly for the use of keeping complete medical records and to be able to contact you directly. Your information will never be shared with outside parties. Medical information is only visible to the practitioners of the clinic.

FALL RIVER
COLLABORATIVE HEALTH CARE

Acceptance

( ) I Agree to the above Privacy Policy

Signature_____

Consent to treatment

I agree to participate in assessments and treatments given by the physiotherapist and the support personnel. I understand that the assessment and treatment services I undergo may be administered by the treating provider and by the support staff under the supervision of the treating provider. I acknowledge that my treatment provider has given me information that is pertinent to my assessment and treatment, including the possible risks and side effects of the proposed treatment.

Acceptance

( ) I Agree to the above Consent to treatment

Signature_____

Dry needling

Dry Needling is a technique where single-use, sterile needles are inserted into muscles to help restore its function and decrease pain. Nothing is injected or taken out of the body.
Dry Needling is a valuable treatment, and like many medical treatments there are possible complications. While these complications are rare, they must be considered prior to giving consent to the procedure.
Any time a needle is used, there is risk of infection. We use single-use, sterile, disposable needles and infection is rare. A needle may be placed inadvertently in an artery, nerve or vein. If an artery or vein is punctured with the needle, a small bruise will develop or localized bleeding when the needle is removed. If a nerve is punctured it may cause a pricking sensation which may persist for days.
When a needle is placed close to the chest wall, there is a rare possibility of accidental puncture of the lung (pneumothorax).
You may experience sweating, nausea, irritation at the site of the needle insertion, or fainting during treatment and drowsiness/fatigue following treatments.
Dry needling may cause post treatment soreness for one or two days, followed by an expected improvement in symptoms.
We ask that patients inform practitioners about medical conditions that may affect Dry Needling treatment and outcomes prior to treatment. Please indicate below if you have any of the following:

FALL RIVER
COLLABORATIVE HEALTH CARE

Are you taking blood thinner medication or have a blood clotting disorder?
( ) yes
( ) no

Do you have a fear of needles?
( ) yes
( ) no

Do you have a history of fainting/syncope?
( ) yes
( ) no

Do you have diabetes?
( ) yes
( ) no

Are you or is there a chance you could be pregnant?
( ) yes
( ) no

Are you aware of any problems or have any concerns with your immune system?
( ) yes
( ) no

Do you have a current or recent infection?
( ) yes
( ) no

Do you have any know disease that can be transmitted through body fluids?
( ) yes
( ) no

Dry needing consent

I have read the above and agree that I understand the risks and benefits involved in Dry Needling treatment. I understand that the results of Dry Needling are not guaranteed. I consent to the use of Dry Needling as a treatment modality by my therapist and I am aware that I can withdraw my consent at any time.

( ) I understand

Signature_____

FALL RIVER
COLLABORATIVE HEALTH CARE

Cancellation/Missed Appointment Policy

Your appointment time is reserved for you. Should you need to cancel or reschedule an appointment, a minimum of 24 hours notice is required. Failure to give adequate notice YOU will be billed in full for your appointment.

Please note, we DO NOT direct bill for missed appointments, and these fees are your responsibility.

( ) I understand and consent to the cancellation/missed appointment policy

Signature_____