Align Physiotherapy

302 – 126 East 15th Street
North Vancouver, BC V7L 2P9

phone: 604-984-0458
fax: 604-984-0036

Intake Form

Name: ______________________ DOB (d/m/y): ____________ Care Card #: ____________

Email: ______________________ Occupation: ______________________

Address: ______________________ City & Province: ______________________

Postal Code: ______________________ Home Phone: ______________________

Cell Phone: ______________________ Work Phone: ______________________

Family Doctor: ______________________ Phone: ______________________

Emergency Contact: ______________ Phone: ______________ Relationship: ____________

Referring Professional: ______________ Phone: ______________ Email: ____________

Previous Treatment

☐ Massage Therapy ☐ Physiotherapy ☐ Chiropractic ☐ Other: ______________________

Medical History

Do you have, or have you had, any of the following:

☐ Abdominal Problems
☐ Arthritis
☐ Asthma
☐ Artificial Joint
☐ Balance Problems
☐ Blurred or Double Vision
☐ Cancer/ History of/ Family History of
☐ Chest Pain
☐ Concussion
☐ Currently Pregnant
☐ Diabetes
☐ Difficulty Swallowing/ Eating
☐ Other
☐ Dislocations
☐ Dizziness
☐ Fractures
☐ Gastrointestinal Disorder
☐ High/Low Blood Pressure
☐ Headaches
☐ Heart Disease/ Family History of
☐ Herniated Disc
☐ Hot or Cold Intolerance
☐ Nausea/ Vomiting
☐ Neurological Disorder
☐ Osteoporosis/ Low Bone Density
☐ Numbness or Tingling
☐ Polio/ Post-polio Syndrome
☐ Psychiatric or Psychological Care
☐ Recent Weight Loss or Gain
☐ Respiratory Condition
☐ Seizures
☐ Shortness of Breath
☐ Skin Condition
☐ Sleep Disorder
☐ Stroke
☐ Ulcers
☐ Vascular Disease

Please list all surgeries and/or significant injuries (with approximate date): ______________________

Please list all medications currently being taken: ______________________

Primary injury or reason for your visit: ______________________

How did you hear about our clinic? ______________________

Cancellations made within 24 hours of your appointment are subject to a $40 cancellation fee. I have read and agree to this cancellation policy.

Patient Signature: ______________________ **Date:** ______________________
(Parent Signature if patient is under 18 years)