Unit 2- 7184 Lantzville Road
Lantzville, BC V0R 2H0
Phone: (250)933-0785
Fax: (250)933-0934
Email: info@lantzvillewellnesscentre.ca

PHYSIOTHERAPY INTAKE FORM

PERSONAL INFORMATION

First Name: ______________________ Last Name: _________________________ Care Card: ________________________

Address: _____________________________________ City: ________________________ Postal Code: ________________

Cell Phone: ___________________________ Home Phone: ____________________________ Gender: _______________

Birthdate (dd/mm/year): ____/____/_______ Email: ____

Emergency Contact Name: _________________________ Phone: ___________________ Relationship: _______________

For your convenience, we can keep a credit card on file:

Number: ________-________-________-________ Expiry: ____/____ CVC: ______

REFERRAL

Family Doctor: ____________________________ Clinic: _____________________________________

Referring Physician: ___________________________ Clinic: _____________________________________

What were you referred for? □ Massage therapy □ Physiotherapy □ IMS □ Shockwave therapy

Have you been treated previously for this same injury? ____

Were you admitted to the hospital for this injury? □ Yes □ No

Have you had X-rays, MRI's, or other tests? ____

How did you hear about us?

□ Internet search □ Friend/ Family □ NRGH □ Live nearby □ Website □ Social media
□ Doctor referral □ Promotion □ Other _____________________

EXTENDED HEALTHCARE COVERAGE

Insurance Company Name	Policy Number	Member Number	Relationship to Cardholder	Name of Cardholder

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HEALTH HISTORY

Have you ever been diagnosed or told you have any of the following?

	YES	NO
High blood pressure		
Diabetes		
Tuberculosis		
Cancer, where?		
Heart or blood diseases		
Bone spurs on the neck bones		
Osteoporosis		
Whiplash injury		
Stroke		
Were you ever a smoker? When?		
Do you take medication on a regular basis?		
Visual disturbances (blurring, loss, double)		
Hearing disturbances (loss, ringing, other noise)		
Slurred speech		
Difficulty swallowing		
Dizziness		
Loss of consciousness, even momentary blackouts		
Numbness, loss of sensation, strength or weakness in the face, fingers, hands, arms, legs, or any parts of the body		
Collapse without loss of consciousness		
Are you immunocompromised?		
Tested positive for AIDS, HIV, Hepatitis C, etc.		
Are you taking blood thinners?		

List ALL medications (prescriptions, herbal supports, vitamins, BCP, aspirin, etc.): ________________________________

____

WORKSAFE BC OR ICBC CLAIM INFORMATION

WSBC Claim: ______________________ **ICBC:** ______________________ **Case Manager:** ________________________

Case Manager Number: ________________________ **Date of Injury (dd/mm/year):** ____/____/________

I give you consent to email my claim information to my Case Manager: □ Yes □ No

Has your employer been notified? (WSBC): □ Yes □ No

Please list any previous surgeries, illnesses, injuries (Motor Vehicle Accident): ________________________________

Can you perform your daily home activities? □ Yes □ Yes, only with help □ Not at all

Lantzville Wellness Centre

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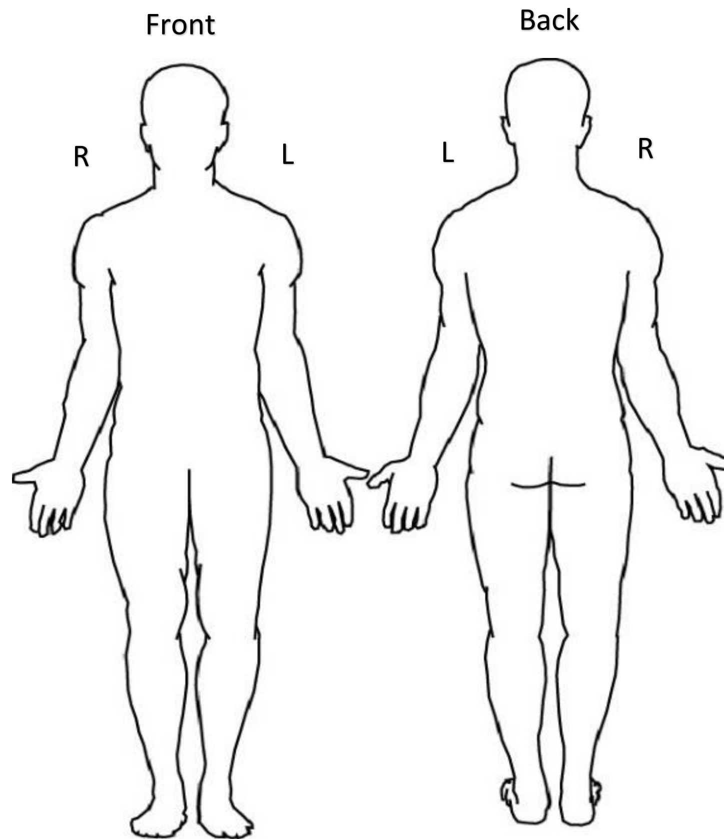
AREA OF PAIN

Indicate the location of your pain by shading the appropriate area:



Indicate the severity of the pain by selecting a number:

□ 0 □ 1 □ 2 □ 3 □4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

No Pain **Extreme Pain**

Additional comments/ concerns: ____

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