FOREST HILL PHYSIOTHERAPY & HEALTH CENTRE
361 Eglinton Ave West • Toronto, ON • M5N 1A3 • Tel: 416.551.7111

Patient Intake

PERSONAL INFORMATION

TITLE: MR. ☐ MRS. ☐ MISS. ☐ MS. ☐ DR. ☐				DATE
FIRST NAME	INITIAL	LAST NAME		OCCUPATION
ADDRESS		CITY	PROVINCE	POSTAL CODE
HOME TELEPHONE	CELLULAR PHONE	BUSINESS PHONE	EMAIL ADDRESS	
BIRTH DATE DAY/MONTH/YEAR	SEX ☐ MALE ☐ FEMALE	HOW DID YOU HEAR ABOUT US?		
IN CASE OF EMERGENCY				
CONTACT NAME		TELEPHONE		RELATIONSHIP

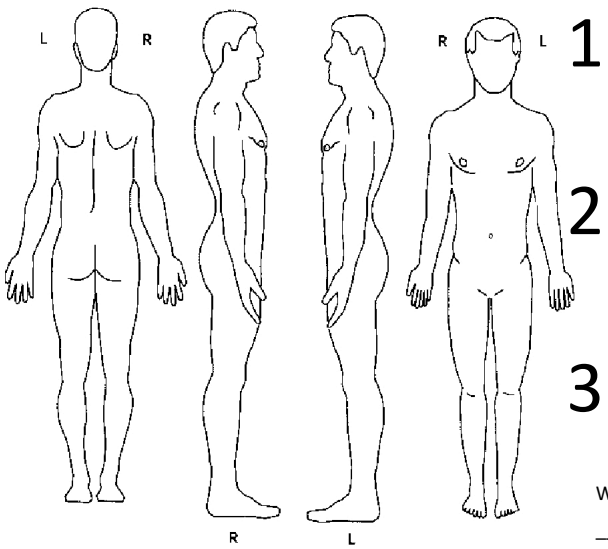
MEDICAL INFORMATION

DO YOU HAVE A MEDICAL DOCTOR? ☐ Yes ☐ No *IF YES, PLEAE COMPLETE THE FOLLOWING.*

DOCTOR'S NAME	DOCTOR'S TELEPHONE NUMBER		LAST VISIT
ADDRESS	CITY	PROVINCE	POSTAL CODE
DO YOU HAVE ANY ALLERGIES	ARE YOU MAKING A CLAIM FOR	1) RECENT MOTOR VEHICLE ACCIDENT ☐ YES ☐ NO 2) WORK RELATED INJURY/ACCIDENT (WSIB) ☐ YES ☐ NO	

CHIEF COMPLAINT

Foot



HOW TO COMPLETE THIS DIAGRAM

On the body to the left, using the symbols below, please mark the location of your primary complaint and described sensation.

Ache	Burning	Numbness	Tingling	Stabbing/Sharp	Deep
XXXX	++++++	^^^^^	******	/////////	======

How did your symptoms start?

- □ sudden
- □ gradual
- □ car accident
- □ work related injury

When did your symptoms start?

- □ 0-3 months ago
- □ 3-6 months ago
- □ 6-9 months ago
- □ 1 year or more ago

Please mark on the line below the level of your discomfort.

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0 no pain — 10 worst pain

What is the reason for seeking care today? _____

_____

Have you sought treatment from any other health care professional? □ YES □ NO

Treatment Received _____

_____