GLENWOOD SPORT & SPINE

DATE: _____

NAME: _____ Male / Female DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____
POSTAL CODE: _____ PHONE #: (h) _____
(w) _____
E-mail address: _____ (c) _____
(optional - for clinic communications)

Medical Doctor: _____ Health Care #: _____

How did you hear of our clinic?
__ from another patient: _____ (name)
__ google (internet) search
__ from my medical doctor
__ walked/drove by
__ other: _____

Marital Status: _____ Occupation: _____
Work / Private Health Insurance: _____
Emergency Contact: _____ Phone Number: _____

Is the reason you came to this office related to a –

| | | |
|---|---|---|
| A) ***RECENT*** Motor Vehicle Accident? | YES | NO |
| B) ***CURRENT*** Work-related injury? (WCB) | YES | NO |

| ***CHIROPRACTIC:*** | |
|---|---|
| Regular Treatment | $75 |
| Re-Assessment | $85 |
| Age 75+ | bill insurance only |
| Assessment | $100 |

| ***SHOCKWAVE THERAPY:*** | $90 |
|---|---|
| ***CUSTOM ORTHOTICS:*** | $500 |
| ***COMPRESSION STOCKINGS:*** | $150-$200 |

| ***PHYSIOTHERAPY:*** | |
|---|---|
| Regular Treatment | $100 |
| Extended Treatment | $150 |
| Assessment | $150 |
| Pelvic Floor Treatment | $135 |
| Pelvic Ext Treatment | $175 |
| Pelvic Floor Assessment | $175 |

| ***MASSAGE:*** | |
|---|---|
| 30 minutes | $65 |
| 45 minutes | $90 |
| 60 minutes | $110 |
| 60 minutes HOT STONE | $130 |
| 90 minutes | $150 |
| 90 minutes HOT STONE | $170 |

| ***ACUPUNCTURE:*** | |
|---|---|
| Acu/IMS 30 min | $100 |
| Acu/IMS 60 min | $130 |
| Cupping & Tuina 30 min | $100 |
| Cupping & Tuina 60 min | $130 |
| Age 75+ | bill insurance only |
| Assessment | $130 |

| ***PSYCHOTHERAPY:*** | |
|---|---|
| Regular Session | $155 |
| Couples Session | $155 |
| Family Session | $225 |

***Unless prior arrangements have been made, services must be paid for at the time they are provided. Fees are subject to change.***
***CANCELLATION NOTICE – 8 hr. notice is required for ALL appointments, NO SHOWS will be charged the regular fee.***
***Acceptance of this form gives Glenwood Sport & Spine consent to obtain insurance coverage information on your behalf.***

# Physiotherapy Intake Form

Name: _____ Date: _____

What is the single AREA that concerns you the most or is your greatest health complaint (headache, neck, low back, knees, etc.)?

_____

What areas are you seeking treatment for today?

_____

Have you had treatments for the same problem/area? Yes ☐ No ☐

If yes, what were they? _____

Are you presently active? Yes ☐ No ☐

If yes, what activites do you/ have you done? (eg. Swimming, walking)

_____

How would you rate your general health status? (circle one)

| Very good | Good | Okay | Bad | Very bad |
|---|---|---|---|---|

Do you have any allergies? If so, please list: _____

Have you ever broken any bones or had severe sprains? Please list: _____

Have you ever been told that you have unusual bone changes?
(spinal instability, scoliosis, unusual pelvis, leg, vertebra etc.) Yes ☐ No ☐

If yes, please describe: _____

Please describe your pain and the location. (e.g. Left toe has a stabbing feeling etc.)

_____

Are you seeing any other doctor now for any reason? Yes ☐ No ☐

Comments: _____

Name: _____ Date: _____

**Have you had any of the following (ever)?**

- ☐ X-ray or Barium x-ray
- ☐ Arterial / Venous Dilation
- ☐ Chemotherapy
- ☐ Bone Scan/Bone Density Scan
- ☐ Back or Neck Surgery
- ☐ Radiation/Radioactive Isotopes
- ☐ MRI or CT (CAT) Scan
- ☐ Heart or Aortic Surgery
- ☐ Knee or Hip replacement
- ☐ Diagnostic Ultrasound
- ☐ Cardiac Pacemaker
- ☐ Artificial joints, pins, wires, metal implants etc.
- ☐ Colonoscopy/Gastroscopy

☐ **I have not had any of the above.**

**Completed Section:** Please initial: _____

**Please check if you have or have been diagnosed with any of these conditions:**

| | **Currently** | **Past (** please specify when) |
|---|---|---|
| Stroke | ☐ | ☐ |
| Cancer | ☐ | ☐ |
| Blood Disorder or Clotting Disorder | ☐ | ☐ |
| Rheumatism | ☐ | ☐ |
| Mental Illness | ☐ | ☐ |
| Diabetes | ☐ | ☐ |
| Heart or Artery Disease | ☐ | ☐ |
| Seizure or any other Neurological Disorder | ☐ | ☐ |
| Asthma/ Allergies | ☐ | ☐ |
| Thyroid Disorder | ☐ | ☐ |
| Pacemaker or other Cardiac device | ☐ | ☐ |
| Metal Implants | ☐ | ☐ |
| ☐ **I have not had any of the above.** | ☐ | |

**Completed Section:** Please initial: _____

**SOCIAL HISTORY:**

Do you smoke/vape nicotine or have you quit recently? Yes ☐ No ☐

Do you consume more than 14 alcoholic drinks per week? Yes ☐ No ☐

Name: _____ Date: _____

**MALE HEALTH HISTORY:**

If you are over 50 years of age, when was your last prostate exam? _____

**FEMALE HEALTH HISTORY:**

Are you pregnant or do you suspect pregnancy? Do you have any problems with or changes in your menstrual cycle? Do you take hormonal birth control medication? Do you take or have you ever taken hormone replacement therapy?

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Yes ☐ No ☐

Do you have a history of any of the following?

☐ ☐ Hysterectomy ☒ Endometriosis ☒ Ovarian Cysts ☒ Chronic pelvic pain

Pelvic inflammatory disease

**Using the symbols below, draw on the area(s) of the body that have pain:**

| | |
|---|---|
| XXX | BURNING |
| / / / | STABBING |
| 000 | ACHING |
| === | NUMBNESS |
| ^^^ | CRAMPING |
| +++ | THROBBING |
| ### | OTHER |