▪ 10030 King George Blvd, Surrey BC ▪ www. Physiozone.ca ▪ info@physiozone.ca ▪ 778 771 4123

PhysioZone Client in-take form

Personal Details	
First Name	
Sur Name	
Gender	
Date of Birth	
Care Card Number (Primary health number)	
Name of doctor	
How did you hear about us?	☐ Social media ☐ Internet search / Google
	☐ Friend/Family ☐ Flyer ☐ Others
Contact Details	
Mobile Number	
Home Number	
E-mail	
Home Address	
Emergency contact Name	
Emergency contact Relation	
Emergency contact Phone number	
MEDICAL HISTORY. Please check if you have / had any of the following	
☐ Have any major health issues?	☐ Had any surgeries / metal implants
☐ Have Diabetes	☐ Have any allergies?
☐ Have Blood Pressure	☐ Had transmittable diseases like HIV, Hepatitis
☐ Have Heart Problems	☐ Have a history of cancer
☐ Have Chest/ Breathing Problems	☐ Have Dizziness / Vertigo
☐ Had Stroke or Aneurysm	☐ Any Previous Motor Vehicle Accidents?
☐ Have Arthritis / Osteoporosis	☐ If female: are you currently pregnant?
Current medications (If you don't know the name, just write for what condition you are taking the medication for?)	
1.	2.
3.	4.
MAIN CONCERNS: (Please list, in order of importance, your chief concerns):	
Concern 1:	**Concern 2:**
How long have you had this condition?	
How did it start?	
What aggravates it?	
What relieves it?	
Please rate your current level of pain on the following scale (tick one): ☐0---☐1--- ☐2--- ☐3--- ☐4--- ☐5--- ☐6--- ☐7--- ☐8--- ☐9--- ☐10	
Would you like to have remainders for your appointments, therapist availability, health education, and other clinic / therapy information? ☐ Yes ☐ No	
☐ I certify that the above information is correct to the best of my knowledge Print Name:	

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