



**In order for the practitioners to provide you with the best possible care the following confidential information must be completed.**

Date: \_\_\_\_\_

Patient's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Sex: M F AHC#: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Email Address: \_\_\_\_\_

Referred by: \_\_\_\_\_

Have you worked with a trainer/athletic therapist before? \_\_\_\_\_ If yes, who and where?  
\_\_\_\_\_

What is your main concern? \_\_\_\_\_

When did it begin? \_\_\_\_\_

Have you had this or a similar complaint before? \_\_\_\_\_ If yes, explain:  
\_\_\_\_\_

Does anything aggravate it? \_\_\_\_\_

Does anything make it better? \_\_\_\_\_

How severe is the pain?

0 1 2 3 4 5 6 7 8 9 10  
(no pain) (extreme Pain)

How often does the complaint occur? \_\_\_\_\_

How long does it last? \_\_\_\_\_

Does the complaint interfere with your: (circle all that apply)

Work Sleep Daily routine Recreation

Activities/movements difficult to perform? (circle all that apply)

Sitting Standing Walking Lying down Bending



Have you received any other treatment for your complaint?\_\_\_\_\_ If yes, please specify from the following:

Massage Therapy

Medical Doctor

Physiotherapist

Chiropractor

Surgeon

Other:\_\_\_\_\_

Are there any other concerns/complaints?\_\_\_\_\_

**Past History**

	Describe	Date
Surgeries:	_____	_____
Injuries:	_____	_____
Auto accidents:	_____	_____
Hospitalizations:	_____	_____
Major illnesses:	_____	_____

Are you currently taking any medications? (include aspirin, ibuprofen, antihistamines, birth control, supplements, etc...)

\_\_\_\_\_

Do you have any allergies?

\_\_\_\_\_

Do you have any medical conditions? (circle all that apply)

Diabetes

Asthma

Heart conditions

Epilepsy

Hernia

Arthritis

Cholesterol

Eye problems

Hearing loss

Thyroid

Ulcer

High or Low Blood Pressure

Name of your medical Doctor: \_\_\_\_\_

What are the main goals you want to accomplish with your visit(s) to Physical Solutions:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_



**REVIEW OF SYSTEMS**

Circle any of the following that you currently have or have experienced in the past 6 months:

<p><b>GENERAL</b> Nervousness Irritability Depression Fatigue Sleep disturbances Change in weight Fever</p> <p><b>MID BACK</b> Mid back pain Pain b/w shoulder blades Sharp stabbing pain Muscle spasms</p>	<p><b>NECK</b> Neck pain Stiff neck Grind/pop/grate sounds Muscle spasms Masses or swelling</p> <p><b>CHEST</b> Chest pain Shortness of breath Pain around ribs Cough</p>	<p><b>ARMS AND HANDS</b> Pain in upper arm Pain in forearms Pain in hands Pain in fingers Sensation of pins and needles in arms Sensation of pins and needles in fingers Numbness in fingers Cold hands/fingers Swollen joints Sore joints Loss of strength</p>
<p><b>HEAD</b> Headache Entire head Back of head Forehead Temples Migraine Head trauma Dizziness Fainting Light headed Memory loss</p> <p><b>NOSE</b> Nosebleeds Sinus problems</p>	<p><b>LOW BACK</b> Low back pain (LBP) LBP worse with: Working Lifting Stooping Standing Sitting Bending Coughing Sneezing Muscle spasms Masses or swelling</p>	<p><b>HIPS/LEGS/FEET</b> Pain in buttocks Pain in hip joint Pain down leg Pain down both legs Leg cramps Pins and needles sensation in legs Numbness in legs Numbness in feet Numbness in toes Cold feet Cramps in feet Swollen ankles Swollen feet Painful joint in toes Painful knee joint</p>
<p><b>EYES</b> Change in vision Glasses/contacts Blurry vision Double vision Flashes in vision Spots in vision Sensitive to light</p>	<p><b>EARS</b> Ringing in ears Hearing loss Frequent infection Ear pain Bussing in ears Drainage</p>	<p><b>MOUTH/JAW/THROAT</b> Jaw pain Change in taste Hoarseness Trouble swallowing Slurring speech</p>

I confirm that the information I have provided in regards to my current condition and past health history is true to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**Fee Guidelines**

Initial Assessment/New problem	\$120.00*/session
Personal Training/Rehab	\$80.00*/session
Package of 15 or more Sessions	\$70.00*/session
Group Training (2 people)	\$60.00 ea./session
Group Training Package or 15 or more	\$50.00 ea./session

It is policy of Physical Solutions Rehabilitation and Personal Training that regardless of the patient's individual health insurance coverage for athletic therapy, payment must be made a time of service. Receipts are provided for the patient to arrange reimbursement. Our athletic therapist is registered with the Canadian Athletic therapist Association.

\*Packages have an expiry date of 1 year from time of purchase

**\*Cancellations without 24-hour notice and no shows will result in a charge for the scheduled session**

**WAIVER**

I have stated all medical conditions that I am aware of and will update the practitioner of any changes in my health status. I agree to immediately inform the therapist if I experience any pain or discomfort during my treatment/training session so that the rehabilitation/treatment/training can be adjusted to my level of comfort. I assume all risks and responsibilities from any injury or liability that may occur as a result of this session.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_