PROHEALTH
OSHAWA PHYSIO & REHAB

Intake Form

Patient Information		
Date: DD/MM/YYYY		
First Name:	**Last Name**:	**Middle Initial:**
☐ Male ☐ Female		
Email Address:		
Address:		
City		
Province:		
Postal Code:		
Birth date : DD/MM/YYYY		
Cell Phone#:		
Home Phone #:		
Referred to Clinic By:	Insurance Plan	Family / Friend
	Doctor	Close to Work/Home / Website
	Yellow Pages	Street Sign / Other
CARE PROVIDER INFORMATION		
Referring Dr:	Phone:	
Family Physician**:**		
INSURANCE INFORMATION		
Primary Insurance Name:		
Name of policy holder:		
Plan#:	**ID. #:**	
Patient's Relationship to Policy Holder:	Self Spouse Child Other	
Name of Secondary Insurance:		
Name of policy holder:		
Plan#:	**ID. # :**	
Patient's Relationship to Policy Holder:	Self Spouse Child Other	
IN CASE OF EMERGENCY		
Name of Local the Person:		
Relationship to Patient:		
Phone# :		

PAST MEDICAL HISTORY FORM

HEART DISEASE	YES	NO
Heart Attack	○	○
Atherosclerotic	○	○
MyocardialInfarction	○	○
Murmur	○	○
Do you have a pacemaker	○	○

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	○	○
Rheumatoid Arthritis	○	○
Multiple Sclerosis	○	○
Epilepsy	○	○
Gout	○	○
Fibromyalgia	○	○
Diabetes	○	○

LUNGS	YES	NO
Asthma	○	○
Emphysema	○	○
Shortness of Breath	○	○

List all medications you are currently taking: _____

List all surgeries in the past two years (Including dates):

Are you Pregnant? ○ Yes ○ No If so, what week are you in?

Injured Body parts: _____

Have you had any injuries related to work? ○ Yes ○ No

If yes, list body part _____ Date of Injury : _____

Have you had any Auto Accidents ○ Yes ○ No

If yes, list body part _____ Date of Injury :_____

Have you had Physical Therapy or Massage Therapy before? ○ Yes ○ No