RESTORE
PHYSIOTHERAPY

Please complete both sides

Last Name: _____ Date of Birth (Y/M/D): _____ Age: ____
First Name: _____
Address: _____
City: _____ Province: ____ Postal Code: _____
Telephone: Home: _____ Work: _____
Cell: _____
Email: _____

Occupation: _____ Employer: _____
Type of work (office, manual labour, computer): _____
Sporting/Recreational activities: _____

Person to contact in case of emergency (name + phone #): _____

Reason for consultation: _____

How were you referred to us? Please specify:
☐By a doctor _____ ☐By another patient _____
☐By someone in this clinic _____ ☐Find a physio _____
☐Internet _____ ☐Advertising/Publicity _____
☐Other _____

Name your family physician (and phone number): _____
Is your injury the result of a work or automobile accident?
☐Yes ☐No Date of the event: _____

In order to offer you quality service, we require your cooperation. We ask that you:

Notify us **24 hours in advance** of any changes to your appointment. If not, a **cancellation fee equal to 100% of the cost of the service** will be charged and should be paid on the following visit. This 24 hour notice allows us to offer your appointment to someone else and allows the physiotherapist to re-organize his/her schedule without being penalized by your absence. Your cooperation is greatly appreciated. _____ initials

I consent to participate in physiotherapy assessment and treatment at Restore Physiotherapy. I understand that my physiotherapist will collaborate with me in making decisions regarding my assessment and treatment and that I should discuss any questions or concerns regarding my treatment with my physiotherapist. Should I choose not to participate in any portion of my treatment program, I must inform my physiotherapist immediately.

Signature _____ Date _____

Please complete the reverse side

Restore Physiotherapy
#904 – 470 Granville St., Vancouver, BC, V6C 1V5
604-682-7788

RESTORE PHYSIOTHERAPY

In order for your therapist to treat you in a safe manner, please provide us with the following information on your health and lifestyle. Thank you for your cooperation.

Are you pregnant? ☐ Yes ☐ No

Pregnancies and deliveries (number and year): _____

Do you wear a pacemaker? ☐ Yes ☐ No

Have you ever suffered or do you currently suffer from the following conditions?

	Yes	No
• Digestive problems	☐	☐
• Headaches	☐	☐
• Insomnia	☐	☐
• Orthopaedic problems (including fractures)	☐	☐
• Major traumas (accidents, falls)	☐	☐
• Osteoporosis	☐	☐
• Inflammatory illness	☐	☐
• Major infections	☐	☐
• Cardiac problems (high blood pressure, heart disease)	☐	☐
• Respiratory problems	☐	☐
• Cancer	☐	☐
• Diabetes	☐	☐
• Have you ever been operated on?	☐	☐

List of surgeries — Year

_____ _____

_____ _____

_____ _____

_____ _____

	Yes	No
• Do you have a fever?	☐	☐
• Have you lost significant weight in the last 6 months?	☐	☐
• Do you have metal implants?	☐	☐
• Do you wear contact lenses or glasses?	☐	☐
• Do you drink alcohol on a regular basis?	☐	☐
• Are you a smoker?	☐	☐
• Do you have any allergies (medication, respiratory, food)	☐	☐
If yes, which ones: _____		
• Do you take any medications?	☐	☐
Which ones and why? _____		

Are you presently in treatment with another health professional? ☐ Yes ☐ No

For what reason(s)? _____ Profession _____

We thank you for the confidence you have shown us!

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