



Intake Form

Personal Information

Name: _____ Date: _____

Age: _____ Birth Date: _____ Sex: M F

Address: _____ City: _____

Province: _____ Postal Code: _____

Telephone: (Home) _____ (Work) _____

Email: _____

Occupation: _____ Employer: _____

Marital Status: Married Single Widowed Divorced Separated Common-law

Number of Children: _____

Family Physician: _____ Referring Physician: _____

Phone number: _____ Fax number: _____

In case of emergency contact: _____

Relationship: _____ Phone number: _____

Address: _____

Insurance/benefits: _____

How did you hear about me? _____

Have you seen a Physiotherapist before? Yes No

If yes, for what ailment(s)? _____
