physiomobility HEALTH GROUP
6 Maginn Mews, Suite 211 Toronto, ON M3C 0G9
Phone: 416-444-4800 | Fax: 416-444-4811
www.physiomobility.com | reception@physiomobility.ca

GENERAL INTAKE FORM

Patient ID: _____ (For Office Use)

CONTACT INFORMATION

Last Name: _____ First Name: _____

Date of Birth (mm/dd/yyyy): _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Home Phone #: _____ Work Phone #: _____

Cell # (Necessary for phone & text reminders): _____

Physiomobility Health Group staff may leave phone messages at provided numbers for confirmation or changes to your scheduled appointments. (Please inform our administration staff if you do not want us to leave phone messages)

E-mail: _____

By providing your email, you are consenting to email communication from Physiomobility Health Group such as appointment reminders, statements, invoices, exercise instructions, newsletters & promotional messages. If you wish not to receive promotional communications, please inform us.

Emergency Contact's Last name: _____ First Name: _____

Emergency Contact's Phone Number: _____

Relationship: _____

Family Physician's Name: _____

Family Physician's Phone Number: _____

Referred by: ☐Doctor *(check only if you have been referred to physiomobility by your doctor)*

Referring Physician (if different from family physician): ☐Neurologist ☐ENT ☐Sports Med

Referring Physician's Name: _____

Referring Physician's Phone Number: _____

Who should we thank for referring you? _____

☐Family / Friend / Patient

☐Internet ☐Facebook / Instagram ☐Events

☐Staff ☐Work/Live in Shops at Don Mills Complex

☐Others (Please specify): _____

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GENERAL HEALTH HISTORY

The health information requested on the following form will assist us in treating you safely. If you have any questions about the requested information, please feel free to ask.

Do you currently have or have you previously had any of the following conditions?

☐Cancer: _____ ☐Stroke/CVA

☐Hepatitis ☐Lung Conditions

☐HIV/AIDS ☐Epilepsy Other

☐Arthritis ☐Heart Disease: _____

☐Osteoporosis ☐Other: _____

(For Women) Are you currently pregnant? ☐Yes ☐No How many weeks? _____

Due Date: _____ Do you have any other children? ☐Yes ☐No

Do you currently (or within the past year) have any of the following symptoms?

☐Loss of Balance/Co-ordination ☐Unexplained Weight Change

☐Dizziness/Blackouts ☐Numbness in any part of your Body

☐Unrelenting Night Pain ☐Seizures

☐Depression ☐Anxiety

Do you have? ☐Metal implant ☐Pacemaker

Past relevant operations: _____ Date: _____

Medication List	**Prescribed For**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please tell us what your primary goals are or what you wish to achieve at Physiomobility?

_____

_____

_____

_____

Clear Save Print