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

PELVIC 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): ☐OB/GYN ☐Midwife ☐Urologist

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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CONFIDENTIAL HEALTH PROFILE

Primary Reason for Consultation: _____

Past relevant operations: _____ Date: _____

Please check all boxes that apply to you:	Yes	No		Yes	No
Heart/Circulatory	☐	☐	HIV/AIDS	☐	☐
Diabetes	☐	☐	Stroke/CVA	☐	☐
Breathing/Respiratory	☐	☐	Skin conditions/Bruising	☐	☐
Dizziness/Fainting	☐	☐	Digestive	☐	☐
Rheumatoid Arthritis	☐	☐	Cancer	☐	☐

Urogenital:

☐ Interstitial Cystitis ☐ Prostatitis ☐ Pelvic Organ Prolapse

☐ UTIs ☐ Urinary Incontinence ☐ Vaginismus ☐ Vulvodynia

ACTIVITY LEVEL

Please check all current activities and activity goals appropriately:

Current	Goal	Current	Goal
☐ Running	☐	☐ Walking	☐
☐ Golf	☐	☐ Cycling	☐
☐ Yoga	☐	☐ Fitness	☐
☐ Swimming	☐	☐ Other: _____	

Are you currently pregnant? ☐Yes ☐No How many weeks? _____

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

Allergies (Please mark)	Yes	No
Latex	☐	☐
Vinyl	☐	☐
Silicone	☐	☐
Gel	☐	☐
Coconut Oil	☐	☐
Other: _____		

Medications / Creams (Please List)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Anything else that you like your therapist to know: _____

_____

_____