Primal Human Performance

CLIENT INTAKE FORM

31 Jevlan Drive
Vaughan ON
L4L 8C2
Phone/fax/text: 905-850-7779

Name:
DOB (mm/dd/yyyy):
☐ Male ☐Female ☐ Not Specified
Address:
City:
Province: Postal Code:
Cell Phone:
Home Phone:
Work Phone:
Email address:
Occupation: Employer:
Emergency Contact:
Emergency Contact phone:
Family Doctor (name, phone):
How did you hear about our clinic? ☐ Website ☐ Referral ☐Other
If via referral, I was referred by:

PRIMAL HUMAN PERFORMANCE CLINIC POLICIES

Appointment Cancellation/Reschedule Policy

Any appointments cancelled or rescheduled less than 24 hours in advance, or any missed appointments, will be subject to a full fee charge for the scheduled visit. Unfortunately, patients who are late for their appointments cannot be guaranteed full treatment for that day although our best efforts to accommodate will always be made.

Please initial here:_____

Authorization to Share Patient Information

It may be necessary for your therapist or trainer and/or their office personnel to communicate with others involved in your care or with your family doctor or other medical specialists in order to ensure quality care.

◯ I consent to the sharing of my health information as described above Initial
◯ I do not consent to the sharing of my health information Initial

Consent to Electronic Communications

In order to provide improved and efficient communication with clients, our therapists and/or their office personnel may wish to communicate with you via email as an adjunct to your in-office visits. We require your consent to utilize this mode of communication.

I understand and accept the risks to privacy associated with communicating electronically via non-secure e-mail services and I agree that email will not be used in emergencies or for transmitting sensitive medical information.

Please initial here:_____

Please acknowledge here that you have fully read and understood the above policies.

Name: DOB (mm/dd/yy):

Signature: Date:

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HEALTH HISTORY

NAME: Signature:

DOB (mm/dd/yyyy): Date:

In order to ensure safe and optimal care, we require the following information. This information will be kept confidential unless allowed or required by law. Please indicate conditions you are experiencing or have ever experienced:

RESPIRATORY:	CARDIOVASCULAR:	WOMEN:
☐ chronic cough	☐ high blood pressure	☐ pregnant
☐ shortness of breath	☐ low blood pressure	☐ breastfeeding
☐ bronchitis	☐ irregular heart rate	
☐ asthma	☐ angina or chest pain	MUSCULOSKELETAL:
☐ emphysema	☐ heart attack	☐ upper back pain/injury
	☐ stroke	☐ lower back pain/injury
INFECTIONS:	☐ pacemaker	☐ shoulder pain/injury
☐ hepatitis	☐ heart disease	☐ arm pain/injury
☐ HIV/AIDS	☐ congestive heart failure	☐ leg pain/injury
☐ tuberculosis	☐ blood clots (DVTs)	☐ knee pain/injury
☐ infectious skin conditions	☐ circulatory problems	☐ ankle pain/injury
☐ herpes		
HEAD/NECK:	OTHER:	OTHER:
☐ headaches/migraines	☐ loss of sensation/pins & needles	☐ sciatica
☐ neck pain/stiffness	☐ arthritis	☐ nausea or vomiting
☐ ear issues/hearing loss	☐ diabetes	☐ hemophilia
☐ vision loss or disturbance	☐ allergies	☐ osteoporosis
	☐ epilepsy	☐ mental illness
	☐ cancer	☐ artificial joints
	☐ thyroid condition	☐ special equipment
	☐ bowel/bladder condition	☐ dizziness or fainting
	☐ speech/swallowing problems	☐ surgical hardware

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No
If yes, for what? _____

Current medications:_____

Previous injuries/surgeries:_____

Have you had any of the following tests done recently? ☐ X-ray ☐ MRI ☐ CT scan ☐ EMG/ nerve conduction ☐ Bone scan ☐ Blood work

Please state when and where:_____

Have you had any unexplained weight loss or weight gain in the past 6 months? ☐ Yes ☐ No

Do you wear orthotics or special shoe inserts? ☐ Yes ☐ No

Have you ever received any of the following treatments? (physiotherapy, chiropractic, massage therapy, radiation, chemotherapy, dialysis)

If so, when and where?_____

Please describe the reason for your current therapy appointment? (e.g. site of pain or injury, recent surgery, health goals etc)

_____

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