

# 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  
 I do not consent to the sharing of my health information

### 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: \_\_\_\_\_

**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:

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

\_\_\_\_\_