physioactive
movement for life

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Mr. / Ms. /… _____ **Date:**_____
First Name: _____ **Home Phone:** (___)_____
Last Name: _____ **Bus. Phone:** (___)_____
Address: _____ **Cell Phone:** (___)_____
City: _____ **Date of Birth:** DD MM YY
Postal Code: _____ **Email:** _____
I authorize Physioactive to send me reminders and information through e-mail _____
Occupation: _____ **Emergency Contact:**_____

Have you received treatment (physiotherapy/massage/osteopathic) before?_____
Did a health Care Practitioner refer you for physiotherapy/massage/osteopathic treatment?_____
Main Sports/Leisure Activities: _____
Diagnosis/Area of Pain: _____ **Date of Injury:** _____
Medications: _____
Previous Surgeries (with date): _____
Motor Vehicle Accident (check if applicable): ☐ **Date of MVA**: _____

Referring Physician (Name & Address): _____

Family Physician (Name & Address): _____

Consent to Contact Physicians: (please initial) Yes _____ ☐ No

How did you hear about us? Walk-in ☐ Google ☐ Doctor ☐ _____ Friend/Family ☐ _____
Other _____

General Health Questions: (please check/circle if applicable; past or present; Add Comments/Dates if applicable)

Osteoporosis	☐	Cancer (or history of)	☐
High Blood Pressure	☐	Steroids/Prednisone	☐
Low Blood Pressure	☐	Lack of Sensation	☐
Heart Problems	☐	Fainting/Drop Attacks	☐
Heart Attack	☐	Loss of Balance	☐
Diabetes Mellitus	☐	Skin Conditions	☐
Epilepsy/Seizures	☐	Internal Pins, Wires, Artificial Joints	☐
Rheumatoid Arthritis	☐	Infections: TB/HIV/Herpes	☐
Ankylosing Spondylitis	☐	Ear problems/Hearing Loss	☐
Reiter's/Crohn's Disease	☐	Pregnancy (due) _____	☐
Pacemaker	☐	History of Headaches/ Migraines	☐
Bowel or Bladder Problems	☐	Recent Unexpected Wt. Loss	☐
Phlebitis/Varicose Veins	☐	Vision Problems: Blurred/Double	☐
Hepatitis	☐	Other Conditions _____	☐

NOTE: A fee will be charged if less than 24 hours notice is given. Please initial _____

For permission to use our personalized digital video home exercise prescription software:
I, _____, give consent to *PHYSIOTEC* via the intervention of a therapist, to use the *PHYSIOTEC* software in order to prescribe the care and services required my state of health, all for my benefit and according to how it was presented to me.I give *Physioactive Orthopaedic & Sports Injury Centre,* by a therapist, the authorization to transmit the information necessary for the prescription of health care services required for my state of health, in the utmost of confidentiality and in respect of all applicable laws, on the web server associated with the use of *PHYSIOTEC* software, property of *Rapidenet Canada* located 105 Beausejour, suite 202, Laprairie (Qc) J5R 5T6, Canada. This consent ceases to take effect when a prescription of services from my therapist required by my state of health is terminated.

Signature:_____ Date: _____

physioactive movement for life | ORTHOPAEDIC & SPORTS INJURY CENTRE

Patient Specific Functional Scale

Name:_____ **DOB:** _____ **Date:** _____
Baseline Assessment _____ **Follow-up Assessment** _____

Identify up to 3 important activities that you are unable to do or have difficulty with, as a result of your problem.

Activity #1:_____

0 1 2 3 4 5 6 7 8 9 10
Unable to perform activity — **Able to perform activity at pre-injury level**

Activity #2: _____

0 1 2 3 4 5 6 7 8 9 10
Unable to perform activity — **Able to perform activity at pre-injury level**

Activity #3: _____

0 1 2 3 4 5 6 7 8 9 10
Unable to perform activity — **Able to perform activity at pre-injury level**

Screening Questionnaire

Using the figure(s), please shade in the area(s) in which your pain is located. Be sure to point out how much area is involved. Does it vary in intensity? Please mark an "X" on the figure(s) below to indicate the area(s) of worst pain and draw arrows to show where it spreads.