TRIANGLE PHYSIOTHERAPY & REHABILITATION

PATIENT REGISTRATION FORM

Last Name:		First Name:
Date of Birth:		Gender: ☐ M ☐ F
Apt/Suite/Unit No:	Street:	
City:	Postal Code:	
Home Tel. #:	Work Tel. #:	Cell #:
E-mail:		Occupation:
Referring Physician:		Telephone:

HOW DID YOU HEAR ABOUT US? (MARK ALL THAT APPLY)

☐ I have been here before ☐ Doctor's Referral ☐ Yellow Pages Book ☐ yp.ca ☐ Google search
☐ Friend/Family/Co-Worker (please name) _____ ☐ Sign Board
☐ Just Walked In ☐ Flyer ☐ VennGo ☐ Other: _____

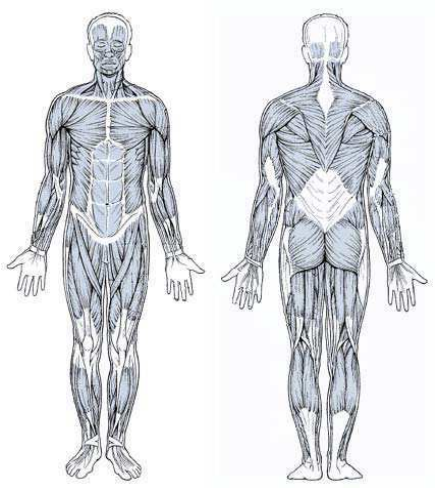
MEDICAL HISTORY

☐ Heart Disease	☐ Osteoporosis	☐ Pace Maker	☐ Double Vision	☐ Nausea
☐ Diabetes	☐ Arthritis	☐ Hearing Aid	☐ Night pain	☐ Dizziness
☐ Cancer	☐ Skin Condition	☐ Metal Implants	☐ Headaches	☐ Recent weight loss
☐ H. Blood Pressure	☐ Intra-Uterine Device	☐ Kidney Ailments	☐ Trouble with speaking/swallowing	
☐ Are you pregnant?	☐ Allergies If YES, please specify _____		Others: _____	

Have you had any major surgery? ☐ Y ☐ N If YES, please specify. _____

List any medications you are presently taking. _____

_____

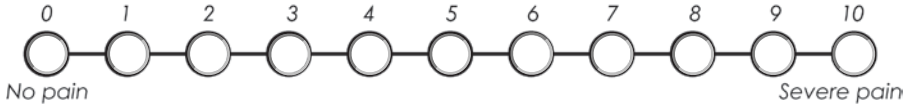


Investigations: ☐ X-Ray ☐ MRI ☐ Ultrasound ☐ CT Scan
☐ Other: _____ If YES, when & where? _____

Location / symptoms you are presently experiencing (indicate on diagram):

_____

Pain Scale: Indicate the severity of your symptoms on the following scale.



Pain Behaviour: Is your pain: ☐ Improving ☐ Worsening ☐ The same
Is your pain: ☐ Constant ☐ Intermittent

Describe your pain (dull, ache, sharp etc.): _____

What activities make your pain: Worse: _____

Better: _____

Since when are you experiencing the above symptoms? _____

Cause of above symptoms (if known) _____

If you wake up tomorrow & have no symptoms, what are the things/activities you would like to do?

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

_____ _____

Signature **Date**