Gastown Physio Pilates

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PERSONAL INFORMATION

NAME (LAST, FIRST)	DOB (MM/DD/YYYY)	BC CARECARD #

ADDRESS	PHONE (PRIMARY)
	PHONE (ALTERNATIVE)
	EMAIL
	OCCUPATION

INSURANCE PROVIDER MEMBER ID PLAN NUMBER	MEDICAL DOCTOR NAME MEDICAL CLINIC CONTACT INFORMATION	IS THERE ANOTHER HEALTH PROVIDER THAT YOU WOULD LIKE US TO CONTACT? NAME AND CONTACT

ARE YOU INTERESTED IN ONE OR SEVERAL OF THESE SERVICES?	❑ REGISTERED MASSAGE THERAPY	❑ IMS (DRY NEEDLE) ❑ ACUPUNCTURE	❑ CLINICAL PILATES ❑ WEIGHT-LIFTING	❑ REGISTERED NATUROPATHY
REFERRED BY	❑ SEND NEWSLETTER BY EMAIL		❑ MVA / ICBC	❑ WCB / WORKSAFE

GENERAL HEALTH

PLEASE INDICATE IF YOU HAVE A **CURRENT (OR PREVIOUS) DIAGNOSIS** INVOLVING:

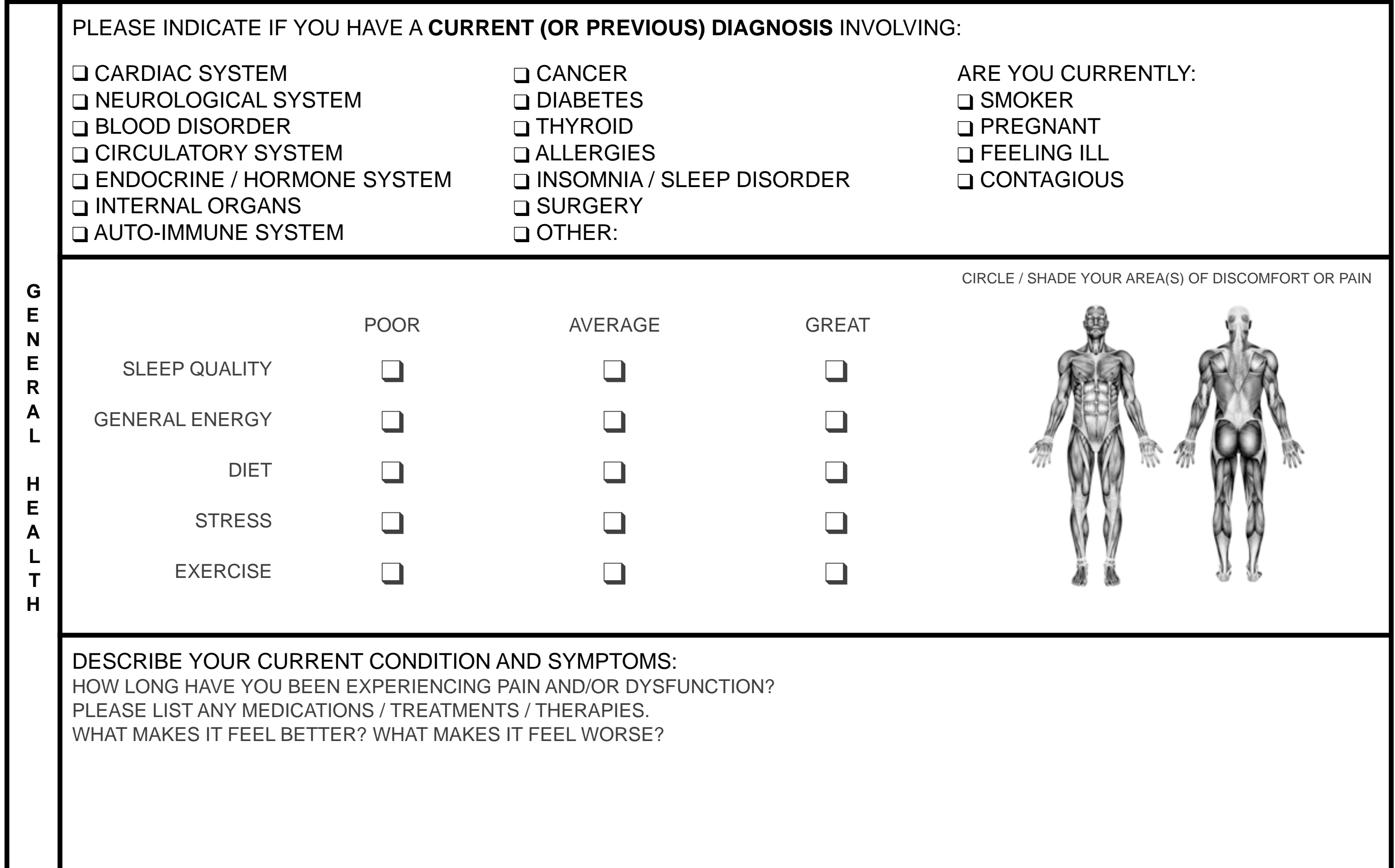
❑ CARDIAC SYSTEM
❑ NEUROLOGICAL SYSTEM
❑ BLOOD DISORDER
❑ CIRCULATORY SYSTEM
❑ ENDOCRINE / HORMONE SYSTEM
❑ INTERNAL ORGANS
❑ AUTO-IMMUNE SYSTEM

❑ CANCER
❑ DIABETES
❑ THYROID
❑ ALLERGIES
❑ INSOMNIA / SLEEP DISORDER
❑ SURGERY
❑ OTHER:

ARE YOU CURRENTLY:
❑ SMOKER
❑ PREGNANT
❑ FEELING ILL
❑ CONTAGIOUS

	POOR	AVERAGE	GREAT
SLEEP QUALITY	❑	❑	❑
GENERAL ENERGY	❑	❑	❑
DIET	❑	❑	❑
STRESS	❑	❑	❑
EXERCISE	❑	❑	❑

CIRCLE / SHADE YOUR AREA(S) OF DISCOMFORT OR PAIN



DESCRIBE YOUR CURRENT CONDITION AND SYMPTOMS:
HOW LONG HAVE YOU BEEN EXPERIENCING PAIN AND/OR DYSFUNCTION?
PLEASE LIST ANY MEDICATIONS / TREATMENTS / THERAPIES.
WHAT MAKES IT FEEL BETTER? WHAT MAKES IT FEEL WORSE?

PHYSICAL ACTIVITY

ON AVERAGE, BEFORE YOUR INJURY, HOW MANY **DAYS** (OUT OF 7 IN A WEEK) DID YOU PARTICIPATE IN **30-60 MINUTES TOTAL** (ADD SMALLER TIME PERIODS TOGETHER) **IN EACH (x15) OF THE ACTIVITY CATEGORIES?**
IF YOU ARE DEALING WITH A CHRONIC INJURY, PLEASE DESCRIBE CURRENT ACTIVITY LEVELS.

	AT HOME	GETTING AROUND	LEISURE	SPORT	EXERCISE
MINIMAL TO LOW EFFORT	VIGOROUS HOUSEHOLD TASKS: SWEEPING, PAINTING, MOWING LAWN / 7	WALKING BRISKLY, SLOW BICYCLE, CLIMBING A FLIGHT OF STAIRS / 7	MODERATE DANCE, HUNTING, WALK WITH ANIMALS, WORKING ON CAR, GARDENING, EASY HIKING / 7	MILD ROWING, CURLING, GOLF, COACHING, SOFTBALL OR BASEBALL / 7	RUNNING A SHORT DISTANCE, LIGHT TO MODERATE CYCLING, “STRETCHING / YOGA TYPE’” EXERCISE CLASS / 7
	“NOT SITTING BUT ONLY MILDLY INCREASED BREATHING”				
LOW TO MODERATE EFFORT	WORK AROUND THE HOUSE: SCRUBBING FLOORS, HOME REPAIR, SHOVELLING SNOW / 7	GENERAL BICYCLE / 7	VIGOROUS YARD WORK, HIKING WITH LIGHT DAY-PACK / 7	MODERATE RECREATIONAL ACTIVITIES LIKE SKIING, DOUBLES TENNIS, THROWING A BASEBALL OR FOOTBALL, ROWING / 7	MODERATE TO VIGOROUS EFFORT ON BICYCLE, “AEROBIC / DANCE TYPE’” EXERCISE CLASS, WEIGHT-LIFTING, ROWING MACHINE / 7
	“SLIGHTLY HEAVIER BREATHING EFFORT BUT ABLE TO HOLD A CONVERSATION"				
MODERATE TO HIGH EFFORT	LIFTING OR MOVING HEAVY FURNITURE, CARRYING BOXES UPSTAIRS, USING HEAVY TOOLS LIKE A SHOVEL/AXE / 7	VIGOROUS BICYCLE / 7	VIGOROUS HIKING UPHILL OR WITH CAMPING SUPPLIES, / 7	PARTICIPATING IN STRENUOUS SPORTS LIKE SWIMMING, SINGLES TENNIS, ULTIMATE, FOOTBALL, BASKETBALL, MOUNTAIN BIKING / 7	VIGOROUS TO STRENUOUS BICYCLE, “HIGH INTENSITY TYPE” EXERCISE CLASS, STAIR-TREADMILL, ROPE SKIPPING, ROWING MACHINE / 7
	“HEAVY BREATHING AND UNABLE TO HOLD A CONVERSATION”				

ACKNOWLEDGEMENT & CONSENT

I understand that by giving consent I (the “Patient”) am voluntarily giving permission for my Health Care Practitioner (the “Practitioner”) to assess and treat my musculoskeletal disorder. I also understand I will be fully informed by the Practitioner towards any potential risks associated with my treatment, as well as potential benefits for treating my condition. My consent may be withdrawn at any time I notify my Practitioner. I also understand that discontinuation of the treatment(s) without consulting my Physician or Practitioner may result in worsening of my condition.

I appreciate there can be no guarantee or assurance as to results and that further treatment may be necessary. I do expect the Practitioner, based on the facts known to them, will work with me in my best interest. I have read the above Acknowledgement and Consent. I have also had an opportunity to ask questions about its content and, by signing below, I agree to treatment by the Practitioner.

I understand that my Practitioner will make every effort to be on time for my appointment and I will extend the same courtesy. I accept that I will be responsible for payment of missed appointments and late cancellations.

Please initial to indicate you are familiar with Gastown Physio & Pilates’ Cancellation Policy. ________________

Signature ____ Date ______________________________

If the patient is under 19 years of age:

I, ____, the parent/guardian of the minor Patient, fully consent to the Practitioner working with my child. I understand the treatment and procedure.