movéo
SPORT & REHABILITATION CENTRE

INTAKE FORM

Name: _____ DOB (m/d/y): _____ Care Card # _____
(as it appears on your Care Card)

Address: _____ Postal Code: _____ Email: _____

Home Phone: _____ Cellular: _____

Occupation: _____ Work Phone: _____

Physician's Name: _____ Phone: _____

Previous Therapies: ☐ Massage Therapy ☐ Physical Therapy ☐ Chiropractic ☐ Other

1. _____ _____
2. _____ _____
Therapist's Name *Last Visit*

Have you, or will you be submitting a claim to:
☐ Insurance Corporation of British Columbia (ICBC) ☐ Accepted ☐ Pending
☐ Worker's Compensation Board (WCB) ☐ Accepted ☐ Pending

Claim Number (specific to this injury): _____ Adjustor's Name: _____

Date of Injury/Accident: _____ Adjustor's Phone: _____

MEDICAL HISTORY:
DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING:

☐ Abdominal Problems
☐ Angina
☐ Arthritis
☐ Asthma
☐ Artificial Joint
☐ Balance Problems
☐ Blurred or Double Vision
☐ Cancer /History of/Family History of
☐ Chest Pain
☐ Concussion
☐ Currently Pregnant
☐ Diabetes
☐ Difficulty Swallowing/Eating
☐ Other _____
☐ Dislocations
☐ Dizziness
☐ Fractures
☐ Gastrointestinal Disorder
☐ High/Low Blood Pressure
☐ Headaches
☐ Heart Disease/ Family History of
☐ Herniated Disc
☐ Hot or Cold Intolerance
☐ Nausea/Vomiting
☐ Neurological Disorder
☐ Osteoporosis/Low Bone Density
☐ Numbness or Tingling
☐ Pacemaker
☐ Polio/Post polio Syndrome
☐ Psychiatric or Psychological Care
☐ Recent Weight Loss
☐ Respiratory Condition
☐ Seizures
☐ Shortness of Breath
☐ Skin Condition
☐ Sleep Disorder
☐ Stroke
☐ Ulcers
☐ Vascular Disease
☐

Please list all surgeries and/or significant injuries (with approximate date): _____

_____

Please list all medications currently being taken: _____

How did you hear about our clinic? ☐ Yellow Pages ☐ Walk By ☐ MD _____ ☐ Friend _____ ☐ Other _____

FEE POLICY:
In consideration of your fellow patients and your therapist please allow a minimum of 24 HOURS NOTICE to change or cancel your appointment. You will be charged the full treatment fee for late cancellations or missed appointments, subject to the therapist's discretion. Please inform us if you are unable to make your appointment. I understand the FEE POLICY.

Patient's Signature: _____ Date: _____

***Please note: For your convenience if you are seeing more then one practitioner this intake form may be shared.**