PEAK HEALTH & PERFORMANCE

Pediatric (0-5 Years) Physiotherapy Intake Form

Patient Information 1/9

Date: DD/MM/YYYY **Child's Name:** **Preferred Name:**

Sex: ☐ Male ☐ Female **Birthdate:** DD/MM/YYYY **Age:** **School Grade Level:**

Alberta Health Care #: **Street Address:**

Mother's Name: **Postal Code:** **City:** **Prov:**

Father's Name: **Email:**

Home #: **Work #:** **Cell #:**

Emergency Contact: **Relationship:** **Phone #:**

** We communicate appointment reminders, invoices, receipts, exercise programs & health tips via email. We hate spam, but we really value educational information. Do we have permission to utilize your email address ?* ☐ *Yes* ☐ *No*

Medical Information 2/9

Family Medical Doctor's Name: **Clinic:**

Date of last MD visit: **Reason:**

Date of last physical examination:

What therapies has your child previously received? ☐ Chiropractic ☐ Massage ☐ Acupuncture ☐ Physiotherapy

** Communication between healthcare providers can greatly improve the quality and safety of patient care. If necessary, do you consent to allow your health provider at PHP to contact your child's medical doctor?* ☐ *Yes* ☐ *No*

Extended Health Benefits & Other Insurance 3/9

Do you have a private insurance plan? ☐ No ☐ Yes (Self) ☐ Yes (Spouse) ☐ Yes (Parent)

Name of primary policy holder (Spouse/Parent):

Policy #: **Which Company?** ☐ Alberta Blue Cross (ABC) ☐ SunLife

Member ID: **Group #:** (ABC Only) ☐ Great West Life ☐ Green Shield ☐ Standard Life

Is this a Workman's Compensation Case (WCB)? ☐ No ☐ Yes ☐ SSQ Financial ☐ Chamber of Commerce ☐ Desjardins

Date of Accident: ☐ Cowan ☐ Industrial Alliance ☐ Johnson

Is this a Motor Vehicle Accident Case (MVA)? ☐ No ☐ Yes ☐ Manulife ☐ Other:

Date of Accident:

How Did You Hear About Us? 4/9

☐ Referred by Friend/Family ☐ Referred by Medical Doctor ☐ Internet/Website ☐ Street Sign

☐ Referred by Trainer ☐ Walk In ☐ Health Care Event ☐ Other:

*Whom may we thank for this referral?

5004 Elbow Drive SW // Calgary, AB, T2S 2L5 // 403-287-7325

Current Health

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Primary Complaint/Purpose of Appointment:

When did this begin?

Has your child had this before? ☐ No ☐ Yes; When: **Is it getting:** ☐ Worse ☐ Better ☐ Not Changing

Is the Condition: ☐ Auto-Related ☐ Sports-Related ☐ Fall ☐ Other:

Has your child seen anyone else for this condition? ☐ No ☐ Yes; Who:

Has your child had any imaging for this condition: ☐ X-Ray ☐ CT ☐ MRI ☐ Ultrasound Date:

Is your child presently taking any medications/supplements?

Are there any secondary complaints/conditions?

Birth History

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Length of Pregnancy: ☐ Full Term (weeks): ☐ Early (weeks): ☐ Late (weeks):

Any issues during pregnancy for mom/baby?

Location of Delivery: ☐ Home ☐ Birthing Center ☐ Hospital

Type of Delivery/Interventions: ☐ Vaginal ☐ Cesarean ☐ Forceps ☐ Vacuum ☐ Breech ☐ Epidural

Length of Labor: ☐ Normal ☐ Difficult **APGAR Scores:** ☐ Jaundice

Birth Weight: **Birth Length:** **Congenital Anomalies:**

Infancy History

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Feeding: ☐ Breast ☐ Bottle ☐ Formula **Latching well:** ☐ Yes ☐ No **Breast Preference:** ☐ No ☐ Left ☐ Right

Sleep Quality: ☐ Good ☐ Fair ☐ Poor **Average Hours/Night:** **Average Hours in a Row:**

Trouble Falling Asleep: ☐ Always ☐ Occasional ☐ Never

General Health History

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Any Known Health Conditions/Illnesses? ☐ No ☐ Yes; List:

Childhood Diseases? ☐ Mumps ☐ Measles ☐ Chicken Pox ☐ Small Pox ☐ Diabetes ☐ Pneumonia ☐ Asthma

Big Falls or Injuries? ☐ No ☐ Yes; List: **Any Allergies?** ☐ No ☐ Yes; List:

Hospitalizations/Surgeries? ☐ No ☐ Yes; List:

Fractures? ☐ No ☐ Yes; Where/When:

Vaccination History:

Health Status Survey

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Please check the box of any conditions or symptoms that your child has had in the past *six months:*

- ☐ Fatigue
- ☐ Difficulty Sleeping
- ☐ Dizziness
- ☐ Fainting
- ☐ Earaches/Infections
- ☐ Sore Throat
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Enlarged Glands
- ☐ Loss of Weight
- ☐ Poor/Excessive Appetite
- ☐ Nervousness
- ☐ Depression/Confusion
- ☐ Hyperactivity
- ☐ Behavioral Problems
- ☐ Frequent Colds/Flu
- ☐ Stomach Aches
- ☐ Diarrhea
- ☐ Eczema
- ☐ Hernias
- ☐ Rheumatic Fever
- ☐ Colic
- ☐ Night Terrors
- ☐ Slow Weight Gain
- ☐ Seizures
- ☐ Bed wetting
- ☐ Constipation
- ☐ Sore Muscles
- ☐ Sore Joints
- ☐ Growing Pains
- ☐ Muscle Cramps
- ☐ Back Problems
- ☐ Neck Problems
- ☐ Pain b/w Shoulders
- ☐ Spinal Curvature
- ☐ Arthritis
- ☐ Difficulty Chewing
- ☐ Walking Problems
- ☐ Feet Turn In/Out
- ☐ Coordination Problems
- ☐ Headaches

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