PEAK HEALTH & PERFORMANCE

Youth (6-12 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

Health History 5/9

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?

General Health History 6/9

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:

Hospitalizations/Surgeries? ☐ No ☐ Yes; List:

Fractures? ☐ No ☐ Yes; Where/When:

Any Allergies? ☐ No ☐ Yes; List:

Vaccination History:

Family History 7/9

Is there a family history of:	Heart Disease	Stroke	Cancer	Diabetes	Arthritis	Other
***Mother's Side:**	☐	☐	☐	☐	☐	
***Father's Side:**	☐	☐	☐	☐	☐	

Lifestyle 8/9

Does your child participate in sports/exercise regularly? ☐ No ☐ Yes; type/frequency:

Does your child have a healthy & balanced diet? ☐ No ☐ Don't Know ☐ Yes, I think so ☐ Yes, definitely

What are your child's daily stress levels? ☐ Extreme ☐ High ☐ Moderate ☐ Low ☐ Very Minimal

What is your child's quality of sleep? ☐ Excellent ☐ Fair ☐ Poor; Hours/night:

Health Status Survey 9/9

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

☐ Sore Muscles	☐ Arm Pain	☐ Fainting	☐ Seizures	☐ Spinal Curvature
☐ Sore Joints	☐ Walking Problems	☐ Loss of Weight	☐ Earaches/Infections	☐ Dizziness
☐ Growing Pains	☐ Feet Turn In/Out	☐ Poor/Excessive Appetite	☐ Sore Throat	☐ Numbness/Tingling
☐ Leg Pain	☐ Coordination Problems	☐ Nervousness	☐ Stomach Aches	☐ Bed wetting
☐ Muscle Cramps	☐ Clumsiness	☐ Depression/Confusion	☐ Diarrhea	
☐ Back Problems	☐ Headaches	☐ Hyperactivity	☐ Constipation	
☐ Neck Problems	☐ Fatigue	☐ Behavioral Problems	☐ Eczema	
☐ Pain b/w Shoulders	☐ Difficulty Sleeping	☐ Epilepsy	☐ Slow Weight Gain	

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