



Vitality
Chiropractic & Laser Therapy Clinic

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Initial Physiotherapy Consultation Form

Name: _____ Initial Visit Date: _____

DOB (M/D/Y): _____ Care Card #: _____

Address: _____ City/Prov: _____

Postal Code: _____ E-mail: _____

Phone #'s H: _____ W: _____ C: _____

Occupation: _____ Benefit Provider(s): _____

Is your visit today related to an **ACTIVE** workplace or motor vehicle injury? Yes No

Who may we thank for referring you? _____

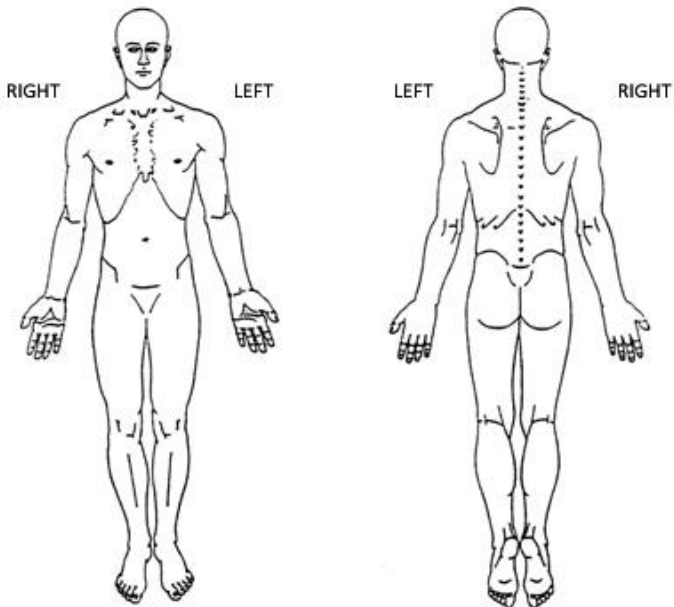
As each patient's needs and goals are unique, so is our approach to patient management and treatment plan design. Which statement best describes the reason you sought the help of our Physiotherapist?

- Diagnose my problem and help me through the initial steps of my recovery.
- Assist me in getting to the point I can return to my work/activity/sport in some fashion.
- Support and guide me all the way to a complete and robust recovery.
- Work with me on an ongoing basis in the pursuit of optimal wellness and injury prevention.

FRONT

BACK

Please indicate any painful or problem spots on the diagram with an 'X'



Primary **COMPLAINT**: _____

How **LONG** have you had this problem? _____

How did it **START**? _____

Have you experienced this problem **BEFORE**? _____

What **AGGRAVATES** your condition? _____

What **RELIEVES** your condition? _____

Does your pain **TRAVEL** to other parts of your body? _____

Is the pain **CONSTANT**? Yes No How **INTENSE** is it at its worst? ___/10 Is it **TRENDING**: Better Worse Same

Does your condition negatively **IMPACT** your: Work Sleep Sports Daily Tasks Mood Relationships

What **OTHER** health professionals have you seen for this condition? _____

What **TREATMENT** did you receive? _____ Was the treatment **HELPFUL**? Yes No

Have you ever had any prior **PHYSIOTHERAPY** experience? Yes No Was this treatment **HELPFUL**? Yes No Somewhat

If you have had previous physiotherapy experience, please describe the **TECHNIQUES** you are familiar with and whether they were helpful.) _____

Do you currently experience any of the following **NEUROLOGICAL** symptoms? Please check all which apply:

- | | | |
|--|---|--|
| <input type="checkbox"/> Dizziness/vertigo | <input type="checkbox"/> Double vision | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Speech difficulties | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Difficulty walking |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Lack of sensation/numbness | <input type="checkbox"/> Confusion |

Explain any of the checked items: _____

List **PREVIOUS** surgeries/accidents/major injuries: _____

List current **MEDICATIONS**: _____

List your regular physical **EXERCISE**: _____

Are there any other **HEALTH** conditions, concerns, or diseases the physiotherapist should be aware of (including pregnancy)?

PHYSIOTHERAPIST'S NOTES: