go!physiotherapy
SPORTS + WELLNESS CENTRE

All information you include is kept completely confidential.
We take great care in storing your information securely.

DATE: ______________________ PHYSIOTHERAPIST: ______________________

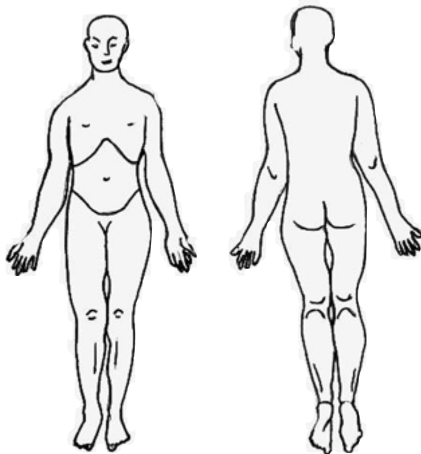
CONTACT INFORMATION				
Last name	First name	Preferred name	Date of Birth (mm/dd/yyyy)	Male Female
Home tel	Mobile tel	Email (for appointment reminders only)		
Street Address		City		Postal code
Care Card Number		Emergency contact name		Emergency contact phone

PHYSICIAN INFORMATION			
Family Doctor	tel	fax	Location or other contact info

How did you hear about us? ☐ Google ☐ Family/Friend ☐ Doctor ☐ Other ______________________________

YOUR TIME IS VALUABLE TO US.
BY PROVIDING THE INFORMATION BELOW, YOUR APPOINTMENT TIME WILL BE USED MORE EFFICIENTLY.

Please circle the area of your symptoms



How would you rate your pain out of 10?
(0=no pain, 10=pain requiring hospitalization)

Briefly describe your symptoms or condition:

Would you describe your pain as (please circle):
Constant intermittent worsening getting better same

What makes it worse?

What makes it better?

Do you experience any pins and needles, burning, or numbness? Where?

Have you had any previous related injuries or symptoms in this same area?

Have you had any other treatment for this injury? E.g. massage, acupuncture, chiropractic, etc.

NAME: ________________________ DATE: ________________ PHYSIOTHERAPIST: ________________

Please indicate all medications you are currently taking:

Please indicate any special investigations you may have had:

xrays CT Scan Ultrasound MRI other________________

Do you have a specialist you are seeing? If so, please indicate his/her name and contact information if available.

Any history of cancer? Recent fever, significant weight loss, or unrelenting pain?

Circle if you have experienced or have been diagnosed with any of the following:

Seizures heart problems osteoporosis osteopenia pacemaker

Are you pregnant?

Please indicate any surgeries you have had:

What is your occupation?

What are your recreational interests?

Other relevant info:

PLEASE READ AND INITIAL	
initial here	Cancellation Policy: "I understand that 24 hours notice is required to reschedule or cancel an appointment, and that I am otherwise responsible for the full fee."

IF THIS VISIT IS FOR A CAR ACCIDENT PLEASE FILL OUT THE FOLLOWING INFORMATION			
Insurer: ICBC	Claim number	Date of injury (mm/dd/yyyy)	Area of injury
Adjuster name		Adjuster phone/email	
I hereby authorize Go! Physiotherapy Sports + Wellness Centre to release any requested medical information to the above named physician, Insurer, my lawyer, employer or their representatives. Dated in Vancouver, BC on __________________________(mm/dd/yyyy)	Signed		Witness

Please remember to come prepared with shorts, tank top and relevant footwear/sporting equipment, as our physiotherapists will need to see the injured area and its surrounding areas. For best results, be on time for your appointment.

THANK YOU FOR COMPLETING THIS FORM AHEAD OF TIME.
We look forward to seeing you soon.