# Jackson Park Physiotherapy

**Welcome to Jackson Park Physiotherapy! In order to serve you better, please take a moment to complete this form. If you require assistance, please see front desk. When finished, kindly return this form to the front desk.**

## Personal Information

Name: _____
Address: _____ Apartment#: _____
City: _____ Postal Code: _____
Birth Date: (day) _____ (month) _____ (year) _____
Phone Number(s) Home: _____
Cell: _____
Email: _____

Do you want a copy of Assessment/Progress/Discharge Reports sent to your physician(s)?

Family Physician: _____ Yes _____ No _____

How did you hear about us? □ Yellow Pages □ Phone Guide (small book)

□ Internet Search □ Other _____

## Employment Information

Employer's Name: _____
Employer's Address: _____
Phone: _____
Occupation: _____

## Emergency contact

Name: _____
Relationship: _____
Phone number(s): _____

**Signature:** _____ **Date:** _____

**Please note 24-hour appointment cancellation notice required to avoid charges.**

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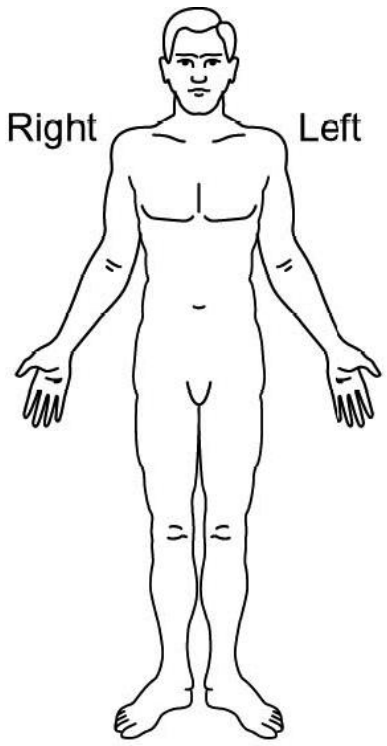
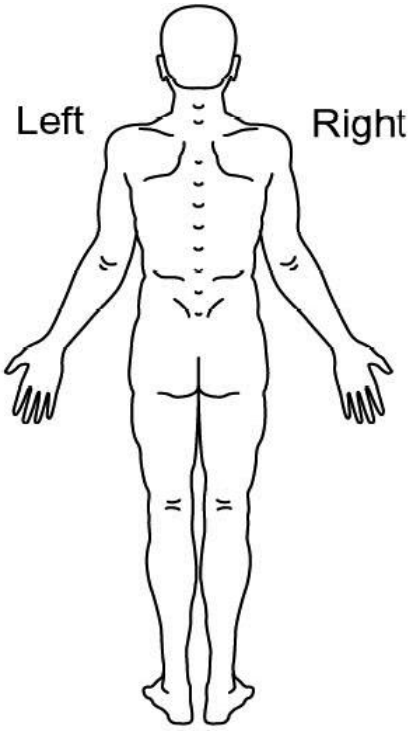
## Medical History

When did your discomfort start?_____

Where is your discomfort? _____

Please locate your discomfort on the following diagram if you wish:




Please rate your discomfort on the following scale (please circle):

1 2 3 4 5 6 7 8 9 10

(no pain) (worst possible pain)

Are you taking medication for this discomfort? ☐ YES ☐ NO

Name of medication: _____

3719 Walker Road ♦ Unit 101 ♦ Windsor, Ontario ♦ N8W 3S9 ♦ 519-250-5775 ♦ Fax: 519-250-1449

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Other medications you are taking: _____

_____

Have you ever had a serious illness or operation?
Please specify: _____

Are you waiting for any surgery to be performed?
Please specify: _____

Do you have a history of family related diseases?
Please specify: _____

Is there any other medical information that may affect your treatment?
Please specify: _____

**PLEASE CHECK IF ANY OF THE FOLLOWING APPLY TO YOU**

| | | |
|---|---|---|
| ☐ Allergies | ☐ Hepatitis | ☐ Arthritis |
| ☐ Asthma | ☐ Kidney Disease | ☐ Bruise Easy |
| ☐ Cancer | ☐ Liver Disease | ☐ Low Blood Pressure |
| ☐ Diabetes, Controlled | ☐ Heart Disease | ☐ High Blood Pressure |
| ☐ Diabetes, Uncontrolled | ☐ Lung Disease | ☐ Pace Maker |
| ☐ Dizziness | ☐ Epilepsy | ☐ Skin Rash |
| ☐ Hearing Aid | ☐ Swelling of the ankles | ☐ Pregnancy |
| ☐ Mental Disorder | ☐ Nervous Disorder | ☐ OTHER |

What do you expect to achieve from therapy? _____

_____