Move Activity & Motion Clinic
116 Guelph St. Unit A
Georgetown, ON L7G 4A3

t: 905-702-1072
f: 905-702-1073
www.moveamc.com

Patient Entrance Form

Name _____ Date _____

Address _____

City, Province _____ Postal Code _____

Home Tel. _____ Cell _____ e-mail _____

Date of Birth (D/M/Y) _____ Age _____

Occupation _____

Employer _____

Address _____

City _____ Phone _____

Emergency Contact _____ Phone _____

Reason for consulting this office _____

How did you hear about our office? ☐ friend ☐ phone book ☐ welcome wagon ☐ family doctor
☐ website ☐ newspaper ☐ other _____

Would you like to receive our newsletter? YES NO

Health Care Professionals

Have you had any regular treatment from any of the following?

☐ General Practitioner (annual) ☐ Chiropractor ☐ Massage Therapist ☐ Physiotherapist
☐ Acupuncturist ☐ Naturopath ☐ Other _____

Medical Doctor

Name _____ Phone _____

Address _____

Date of last appointment _____ Date of last physical _____

FOR OFFICE USE ONLY OTHER ☐ WSIB ☐ MVA ☐ S.I.N. _____ _____ _____

Information in your file may be shared as necessary by the health practitioners within the clinic for the benefit of your health.

Signature _____ Date _____

Collection, use and disclosure of this information is subject to all applicable privacy legislation. Additional disclosure and consent may be required depending on the matter in which the information is used and disclosed.

Patient Past History - General Medical

Falls and accidents - list: _____

Surgery - list: _____

Surgery recommended but not performed - list: _____

Do you have any internal pins, wires, artificial joints or special equipment? YES NO

Please list: _____

Have you ever been knocked unconscious? YES NO Don't Know

If so, for how long? _____

List any medications or drugs you are currently taking _____

Have you previously been hospitalized? YES NO

Please list: _____

Any family health conditions or problems? YES NO

Please list: _____

Please check if you have experienced any of the following:

- ☐ Diabetes
- ☐ Cancer
- ☐ Stroke
- ☐ Heart Attack
- ☐ High Blood Pressure
- ☐ Arthritis
- ☐ Bruise Easily
- ☐ Infectious Disease(s)
- ☐ Chest Pain
- ☐ Pneumonia
- ☐ Asthma
- ☐ Head Aches
- ☐ Dizziness
- ☐ Difficulty Sleeping
- ☐ Sweats
- ☐ Ankylosing Spondylitis
- ☐ Deafness
- ☐ Eye Pain or Loss of Vision
- ☐ Irritable Bowel Syndrome
- ☐ Sinus Infections
- ☐ Osteoporosis
- ☐ Weight Loss

Currently Pregnant Yes No

Show area(s) of pain or unusual feeling:
Mark the areas on this body where you feel the described sensations.

- ☐ Numbness
- ☐ Pins & Needles
- ☐ Burning
- ☐ Aching
- ☐ Stabbing