Victoria Exercise Rehabilitation Centre Ltd.

"Strength, mobility and confidence"

Intake Form

Name:	Date:
Address:	Primary Phone:
Date of birth:	Secondary Phone:
Current Age:	Email:
Personal Health Number:	
Were you referred by a doctor? ☐Yes ☐No	
If yes, Physicians name:	
Do you have a Claim with ICBC? ☐Yes ☐No	
Claim/Policy number:	Date of injury:
Do you have legal counsel? ☐Yes ☐No	
Name:	Company:

Chief Complaint:

Have you received any of the following services before?

Acupuncture: ☐Yes ☐No From:_____ To: _____

Chiropractic: ☐Yes ☐No From:_____ To: _____

Massage Therapy: ☐Yes ☐No From:_____ To: _____

History of health problems such as chest pain or stroke? ☐Yes ☐No

Have you had chest pain brought on by physical activity? ☐Yes ☐No

Episodes of feeling faint, severe dizziness, seizure or epilepsy? ☐Yes ☐No

History of smoking? If yes, how many years? ☐Yes ☐No

History of breathing or lung problems? ☐Yes ☐No

Diabetes or thyroid conditions? ☐Yes ☐No

Has your doctor ever stated that you have joint problems such as arthritis that has been aggravated or made worse by exercise? ☐Yes ☐No

Elevated or low blood pressure? ☐Yes ☐No

Past surgeries? If yes, please describe and date… ☐Yes ☐No

Have you had any X-Rays done? If yes please explain… ☐Yes ☐No

Do you have any other past injuries or other known medical conditions which we should know about?

How long have you been in pain?

- ☐ Less than 2 weeks
- ☐ 1- 3 Months
- ☐ 3 - 6 Months
- ☐ Longer than 6 months

Do you rest during the day due to your pain?

- ☐ Never
- ☐ Occasionally
- ☐ Frequently

Can you do household chores?

- ☐ Yes, Independently
- ☐ Yes, with difficulty
- ☐ No

How does your pain affect the following activities?

	Walking	Sitting	Standing	Self-Care	Lifting	Working
No change	☐	☐	☐	☐	☐	☐
Restricted	☐	☐	☐	☐	☐	☐
Unable to do	☐	☐	☐	☐	☐	☐

Headaches?

- ☐ Never
- ☐ Occasionally
- ☐ Frequently
- ☐ Constant

Dizziness?

- ☐ Never
- ☐ Occasionally
- ☐ Frequently
- ☐ Constant

Sleep patterns…

How many hours of sleep do you get most nights? _____ Hours

Do you wake up rested in the morning? ☐ Usually ☐ Occasionally ☐ Rarely

Occupation: Employer:

Hours per week:

Type of work:
- ☐ Sedentary
- ☐ Light
- ☐ Medium
- ☐ Heavy
- ☐ Very heavy

Are you currently working? ☐ Yes ☐ No
- ☐ Is it due to your injury?
- ☐ Are you on disability
- ☐ Normal hours
- ☐ Modified hours

Are you able to perform normal activities? ☐ Yes ☐ No

If no, please explain:

_____

_____

_____

Please shade in painful areas:

R L L R