Barrie Community Health Centre

# PHYSIOTHERAPY EXTERNAL REFERRAL
# PATIENT INFORMATION FORM

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|---|---|---|
| Date: | | |
| First Name: | Last Name: | Middle Initial: |
| Address: Street: | City: | Postal Code: |
| Phone: | Date of Birth: (mm) / (dd) / (yy) | |
| Health Card Number: | Version Code: (two letters) | Expiry Date: (mm) / (dd) / (yy) |
| Emergency Contact Name: | Phone: | Relation to Client: |
| Family Physician or Nurse Practitioner Name: | | |
| Phone Number: | Fax Number: | |

What are your symptoms and where on your body do you experience them?

Please describe the cause of your symptoms, if known:

Date of injury/surgery/onset:

Please list any procedures/tests done related to your problem with the date and results:

Please describe any resulting functional limitations:

Please describe any other treatment that you have received for this current problem:

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If you have experienced these symptoms in the past, please provide details:

Medications presently taken:

Please check box if any of the below applies to you at this time:

- ☐ Chest or throat infection
- ☐ Bowel or bladder problems
- ☐ Numbness in legs/arms/groin
- ☐ Night pain
- ☐ Pregnant
- ☐ Check if none apply
- ☐ Unexpected weight loss
- ☐ Headaches/dizziness/double vision
- ☐ Pain with deep breath/cough/sneeze
- ☐ Cardiac pacemaker
- ☐ Metal in your body

Please check box if you have a history of:

- ☐ Heart condition
- ☐ Osteoporosis
- ☐ Diabetes
- ☐ Cancer
- ☐ Check if none apply
- ☐ Asthma or COPD
- ☐ Abnormal blood pressure
- ☐ Osteoarthritis
- ☐ Allergies
- ☐ Long-term anticoagulants
- ☐ Long-term steroid use
- ☐ Rheumatoid arthritis

Any other relevant health information:

Signature:

Patient: Date: dd/mm/yy

Physiotherapist: Date: dd/mm/yy

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