ABBOTSFORD SPINE CENTRE

# KINESIOLOGY INTAKE FORM

**File #:** _____

**Date:** _____

**Name:** _____ **Email:**_____

**Address:** _____ **Postal Code:** _____

**Phone:** _____ **Cell:** _____

**Gender:** _____ **Birthdate:** _____ **Care Card #:** _____

***Appointment Reminder:*** **YES ☐ NO ☐** **Circle One: Email / Text / Phone**

☐ Phone call 24 hrs before appointment ☐ Text or Email 1 hr before appointment

☐ Text or Email 24 hrs before appointment ☐ Text or Email 2 days before appointment

**Family Physician:**_____ **Phone:** _____

**Injured Areas:** ☐ Back ☐ Neck ☐ Shoulder ☐ Hip ☐ Knee ☐ Other: _____

**ICBC ☐** **Claim #:** _____ **Date of Injury:** _____

**Are you presently working?** _____

**List of medication(s):**

_____

_____

I hereby consent and give authorization to Abbotsford Spine Centre to release to my family doctor, specialist, other treating therapists, WorkSafeBC, ICBC, or insurance adjusters any clinical information contained in my file with reference to my condition. I understand that ICBC, WorkSafeBC, insurance adjuster or my employer may contact you to establish critical job demands of my position to assess the availability of modified work duties or establish a graduated return to work program. I have read and understand this form and give informed consent to collect and distribute information to these individuals or organizations.
I understand that if my claim is denied, I will be responsible for any outstanding debt incurred.

_____ _____

Signature Date

ABBOTSFORD SPINE CENTRE

**File #:** _____

**Date:** _____

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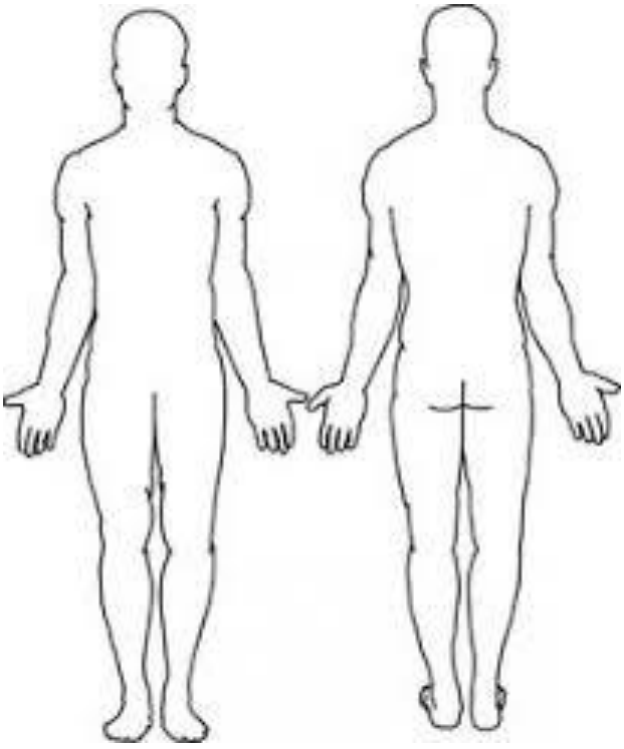
### Interim Pain Diagram & Pain Rating

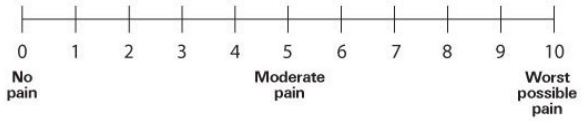
**Name:** _____

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. (Use the Key to indicate the type of symptoms)

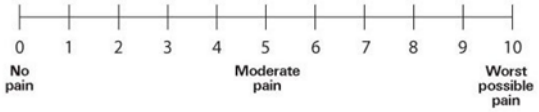
**Key:** Pins and Needles = 00000000 Stabbing/Sharp Pain = ////////
Burning = xxxxxxxx Deep Ache = zzzzzzzz



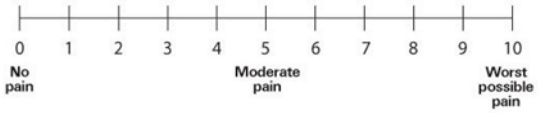
Back Pain:



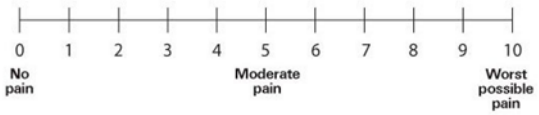

Neck Pain:



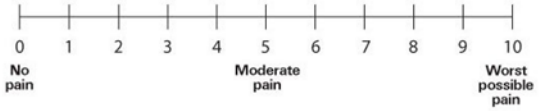

Arm Pain:




Leg Pain




Headache:




What daily activities give you difficulty or increase your typical pain? For example: tying shoes, climbing stairs, sitting cross legged, bending down to pick something up, reaching up to grab something, etc.

_____

_____

_____

Other Comments:

_____

_____