inMotion Intake Form

Name_____ Birth Date _____
Address_____
Phone #_____ Email_____
Family Physician _____ Care Card # _____
How did you hear about inMotion? _____

Is this injury ICBC or WCB related? ___ICBC ___WCB ___ Neither

Personal History – check all that apply

- Arthritis
- Osteoporosis
- Epilepsy
- Stroke
- Diabetes
- Heart Conditions
- Breathing Disorders
- Cancer
- Dizziness/Fainting
- Other _____

Please list any medications you're taking

_____

_____

_____

Allergies: _____

Is this the first time you've been treated for this injury? _____
If no, what other treatments have you had?

_____

_____

Previous Injuries – please list any previous injuries (bone fractures or breaks, surgeries, hospitalizations, etc.)

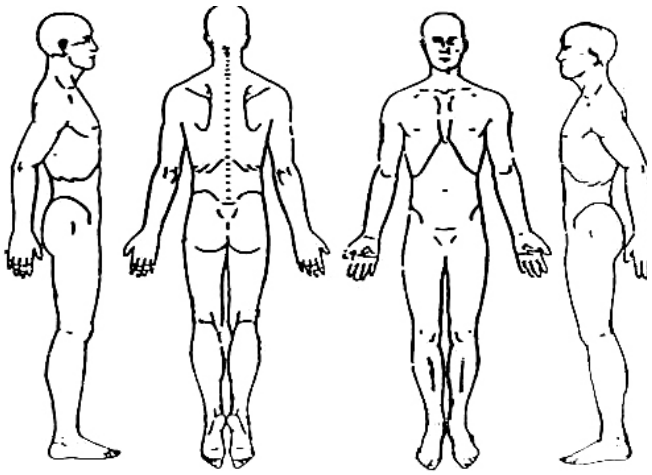
_____

_____

_____

_____

Please mark with a circle where you feel pain.



Brief explanation of what brings you in today (Include date of injury if applicable):

_____

_____

_____

_____