

# 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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

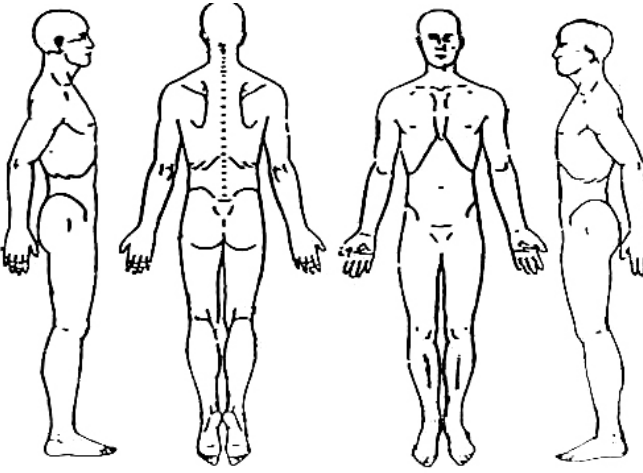
Allergies: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Please mark with a circle where you feel pain.



The image contains four line drawings of a human male figure. From left to right: a profile view of the left side, a back view showing the spine, a front view showing the chest and abdomen, and a profile view of the right side. These are intended for marking areas of pain.

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_