Family Physiotherapy Centre Of London

CLIENT INTAKE FORM

Client Information

Name: _____ Date of Birth: _____

Address: _____

Main phone: _____ Cell phone: _____

Email: _____

How did you hear about this service?

_____

Medical Information

Reason for referral (concerns, symptoms):

_____

_____

Name/address/phone of family doctor:

_____

_____

Medical history/complications:

_____

Family health history:

_____

Current medications:

_____

_____

Vitamins or supplements: _____

_____

Allergies (food, drugs, chemical, other):

_____

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FPC North
2 – 770 South Wenige Drive
London, ON N5X OH7
T: 519.433.9111
F: 519.433.8515

FPC Central
310 Wellington Road South
London, ON N6C 4P4
T: 519.439.6111
F: 519.439.2111

Height: _____ Weight: _____ Ideal Weight: _____

Do you have or have you ever had any of the following (check all that apply):

☐Acid Reflux/Indigestion/Heartburn
☐ Anemia
☐ Asthma
☐ Cancer
☐ Celiac Disease
☐ Constipation
☐ Diverticulitis
☐ Eating Disorder
☐ Gout
☐ Heart Disorder
☐ Hepatitis C
☐ High blood pressure
☐ High cholesterol
☐ High triglycerides
☐ High blood sugars
☐ Inflammatory Bowel Disease
☐ Irritable Bowel Syndrome
☐ Metabolic Syndrome
☐ Obesity/Overweight
☐ Osteoarthritis
☐ Osteoporosis/Osteopenia
☐ Prediabetes or Diabetes

Other chronic conditions?
_____

Diet and Lifestyle

Have you ever seen a Registered Dietitian before? Yes ☐ No ☐

If so, please describe your experience and the results of your consultation(s).

_____

_____

How many hours of sleep do you get in a night? _____

Please rate your stress level in the past week on a scale of 1 to 10 (1 = no stress, 10 = very high stress).

1 2 3 4 5 6 7 8 9 10

How do you manage stress?

_____

Are you physically active on a regular basis? Yes ☐ No ☐

If so, what physical activity do you do?

_____

_____

What is your occupation? Please describe your work schedule and physical activity level at work.

_____

_____

What are your health and nutrition goals?

_____

_____

List any barriers or challenges you have had to achieving success.

_____

_____

How many meals do you eat in a day? _____

Do you snack between meals? Yes ☐ No ☐ Sometimes ☐

Do you eat breakfast every day? Yes ☐ No ☐

How many meals do you eat out per week?
_____

How many frozen/convenience/prepackaged meals do you eat per week? _____

How many home cooked meals do you eat per week? _____

What beverages do you drink (water, milk, coffee, pop, juice, alcohol, etc)?

_____

_____

INFORMED CONSENT

I fully understand that Ayesha Sarathy, RD, MScFN is not a medical doctor and does not dispense medical advice nor prescribe medical treatment.

Nutrition and exercise are intended to promote general health and wellness and are not intended to replace physician care or medical intervention. All nutritional assessment, suggestions and consultation on nutrition, diet and exercise are based on your input, and are not intended to diagnose, treat or cure any disease or ailment.

I accept all responsibility for reviewing diet, nutrition, lifestyle or exercise suggestions with a licensed medical professional before following said suggestions.

I understand that part of the risk involved in undertaking any activity is relative to my own state of fitness and health (physical, mental, and emotional) and the awareness, care and skill with which I conduct myself in that activity or program. I acknowledge that it is my choice to participate in any activity program or service suggested by Ayesha Sarathy. I also acknowledge that I have inquired about the nature of any activity, program, or services that I am not completely familiar with and I have been informed of any inherent risks.

As your general health and wellness may change with modifications in diet, nutrition and lifestyle, physician prescribed medications may require modification. It is your responsibility to discuss this with your physician. Never reduce or eliminate physician prescribed medications without the direction of your physician or medical care provider.

Your personal and health information will remain confidential and will not be shared without your consent.

I give permission for the information provided on this form and discussed in your nutritional consultation(s) to be shared and discussed with the primary care physician you have listed on this form, at the discretion of the Registered Dietitian and in the interest of your general health and wellness.

I declare that I have read, understood, and agree to the contents of this informed consent agreement in its entirety.

Signature: _____ Date: _____

Print Name: _____

CANCELATION AND MISSED APPOINTMENTS

Please help us to maintain the operation of our office on sound principles so that we may assure you and other clients of uninterrupted service. Once you have made an appointment, this time is reserved for you, therefore you must provide us with at least 24 hours NOTICE if cancellation is absolutely necessary – otherwise a $20.00 fee will be charged. Services are paid for at each visit. Packages are paid for in entirety at your first appointment and are non-refundable and non-transferrable.

By signing below, you agree to the above terms and conditions for participation in nutritional consultation with Ayesha Sarathy, RD, MScFN.

Signature: _____ Date: _____

Print Name: _____

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