



DR. EMMANUEL PARENTEAU

PAIN RELIEF & REHABILITATION

1B – 1830 OAK BAY AVENUE VICTORIA, BC V8R 6R2

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INTAKE

Name:	Date:
Address:	Postal Code:
Home Phone:	Work Phone:
Date of Birth:	Age:
E-mail: _____	
<i>(we use email to send patients home therapy instructions as well as a monthly newsletter – from which you may unsubscribe at any time – by giving us your email we assume you are accepting of these uses of your information. Thank you!)</i>	
Family physician: _____	

Private Patient

Insurance Carrier: MSP Premium Assistance Low-Income First Nations Senior citizen

PHN (care card #): _____

Personal Injury

Description: _____ Date of Injury: _____

Claim Number: _____ PHN (care card #): _____

Adjuster (name/phone): _____

Lawyer (name/phone): _____

Work place Injury

Description: _____ Date of Injury: _____

Claim Number: _____ PHN (care card #): _____

CHIEF COMPLAINT(S) (what body area(s) hurt since injury or since pain started):

PREVIOUSLY INJURED THIS AREA (Explain):

TREATMENT(S) TO DATE:

Physiotherapy YES NO if yes, from: _____ to: _____
 Chiropractic YES NO if yes, from: _____ to: _____
 Massage Therapy YES NO if yes, from: _____ to: _____
 Other: _____ YES NO if yes, from: _____ to: _____

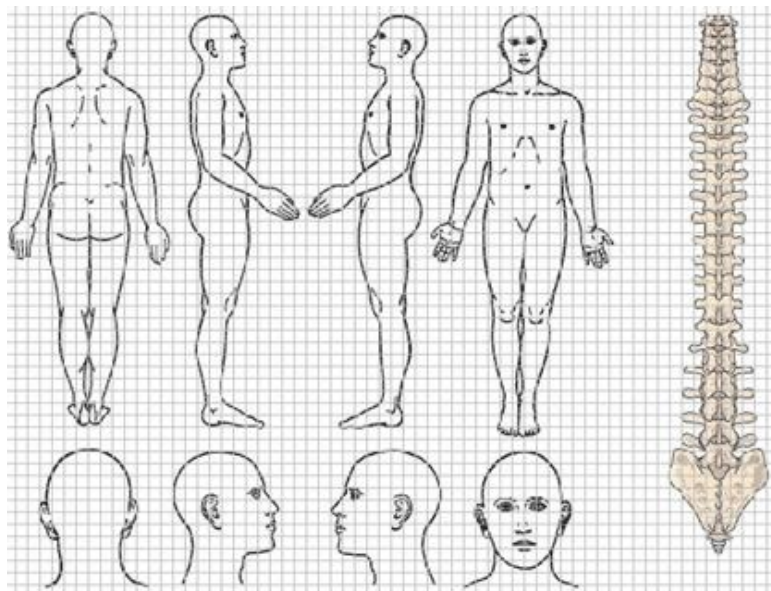
X-rays: YES NO if yes, date and results: _____
 MRI: YES NO if yes, date and results: _____
 CT Scan: YES NO if yes, date and results: _____
 Ultra Sound YES NO if yes, date and results: _____
 Other: _____ YES NO if yes, date and results: _____

Medications: _____
 Surgical History: _____

MEDICAL HISTORY:

Heart problems, chest pains or stroke: NO YES, explain: _____
 Chest pain brought on by activity: NO YES, explain: _____
 Episodes of feeling faint, dizzy, nausea
 epilepsy or seizures: NO YES, explain: _____
 History of smoking: NO YES, explain: _____
 Breathing or lung problems: NO YES, explain: _____
 Diabetic: NO YES, explain: _____
 Bone diseases (e.g.: osteoporosis) NO YES, explain: _____
 Rheumatoid Arthritis: NO YES, explain: _____
 Osteoarthritis (wear & tear arthritis): NO YES, explain: _____
 Any significant past injuries/diseases: NO YES, explain: _____

PAIN DIAGRAM:



Shade in the areas of concern and label them according to the following chart:

P = Pain N = Numbness
 A = Ache PN = pins & needles
 B = Burning S = Spasm

R = Restriction (sensation of being unable to move normally)

O = Other: _____

