



# Haldimand Physiotherapy Centre

41 Caithness Street West, Caledonia, ON, N3W 2J2

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Website: [www.haldimandphysio.ca](http://www.haldimandphysio.ca)

## Welcome Letter

**Welcome! Thank you for choosing Haldimand Physiotherapy Centre to help you with your healthcare needs. We strive to provide you with optimal care as well as an exceptional experience.**

**Intake Forms:** For your convenience, intake forms are available on our website and can be downloaded, printed and filled out prior to your first visit.

**Initial Visit:** Please arrive 5-10 minutes early for your first treatment to complete our intake and sign consent forms. On your assessment day you can expect to be at the clinic for approximately 1 hour. Your initial visit will include a review of your medical history and current symptoms/ injury, full assessment of your area of injury as well as a treatment of the injured area. Your physiotherapist or massage therapist will also discuss your goals and expectations of treatment and together you will discuss a treatment plan.

### **What to wear?**

Physiotherapy- Please wear comfortable clothing that allows for the treatment area to be examined. For example for lower extremity injuries please remember to bring shorts, for upper extremity t-shirt or tank top.

Massage therapy – Patients will undress in the massage room and will be covered appropriately. You and your therapist can discuss what you are most comfortable with on the day of your first visit.

### **Directions to the clinic:**

If you are coming from Hamilton – follow Highway 6 to Argyle Street in Caledonia. At the stop lights (Caithness Street) before you cross the bridge turn right. We are located in the Arrell Place building on the left hand side of the road.

If you are coming from Hagersville- follow Argyle Street North across the bridge and turn left at the first set of lights (Caithness Street). We are located in the Arrell Place building on the left hand side of the road.

If you are coming from Cayuga- take Highway 54 from Cayuga to Caledonia. This turns into Caithness Street East. Continue on this road and cross Argyle Street (Caithness Street West). We are located in the Arrell Place building on the left hand side of the road.

**Parking:** We have ample parking directly behind our building. You may also choose to park on the road in front of the clinic.

**Payment Methods:** We offer private Physiotherapy and Massage Therapy, OHIP funded Physiotherapy (must meet eligibility criteria), Workers Compensation Physiotherapy (WSIB), Motor Vehicle Accident Physiotherapy and Massage therapy, Veterans Affairs Physiotherapy. For private treatment, we accept Cash, Cheque, Debit, Mastercard, Visa. Payment is due on the date of treatment. Many work benefit plans (Extended Health plans) cover our services, we would be happy to help you find out about your coverage.

If you were involved in an MVA please bring the following to your first scheduled appointment:

- Accident Benefit Package (sent to you by your insurance company). We can assist you in filling this out!
- Insurance company name, Claim #, Policy #, Adjuster name and number
- Extended Health coverage (if applicable)

If you were injured at work please ensure that following:

- you have reported your injury to your workplace
- your workplace has reported the injury to WSIB
- bring your claim # with you (if you have not received a claim # please bring your SIN)

Should you have any further questions please do not hesitate contacting us at the clinic at (905) 765-5449.  
Thanks again for choosing Haldimand Physiotherapy Centre!

## Male Symptom Monitor

Presenting Problems:

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When did this start?

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Occupation/hobbies:

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*Please fill out each section that is relevant to your problem*

**Have you had any of the following medical procedures? If so, please provide approximate date.**

Appendectomy:

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Hernia Repair:

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Vasectomy:

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Hemorrhoid Banding:

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Prostatectomy:

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Cystoscopy:

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Urodynamics:

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Gallbladder Removal:

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Bowel Resection:

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Colostomy:

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Colonoscopy:

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Other:

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### **Bladder Symptoms**

Do you have leakage associated with sneezing, coughing, running and/or laughing?

Yes    No    Sometimes

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Do you have leakage during intercourse?

Yes    No    Sometimes

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Do you feel really strong sensations prior to voiding but don't leak?

Yes    No    Sometimes

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Does your leakage occur after having a strong urge that feels uncontrollable?

Yes    No    Sometimes

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Do you have pain when your bladder fills?

Yes    No    Sometimes

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Does your pain improve when you void?

Yes    No    Sometimes

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Do you have pain when you void?

Yes    No    Sometimes

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Do you have to strain in order to empty your bladder?

Yes    No    Sometimes

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Do you have difficulty starting your urine stream?

Yes    No    Sometimes

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Do you have dribbling after you get up from the toilet?

Yes    No    Sometimes

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Do you stand to void?

Yes    No    Sometimes

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Do you have incomplete emptying when you void and feel like you have go again soon?

Yes    No    Sometimes

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Do your bladder problems cause you to leak at night?

Yes    No    Sometimes

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Does your incontinence require you to wear pads?

Yes    No    Sometimes

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If you answered yes or sometimes, how often?

Do you void during the day more often than the average person (5-7x/day)

Yes    No    Sometimes

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If you answer yes or sometimes, how often?

Do you need to get up at night to void?

Yes    No    Sometimes

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If you answered yes or sometimes, how many times?

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**Fluid Intake In 24 hours**

# of cups of water: \_\_\_\_ # of cups of coffee: \_\_\_\_ # of cups of tea: \_\_\_\_

# of cups of other fluids: \_\_\_\_ # of alcoholic drinks: \_\_\_\_

**Digestion & Bowl Function**

What is the frequency of your bowel movements?

Do you feel the urge to move your bowels?	<input type="checkbox"/> Always	<input type="checkbox"/> Seldom	<input type="checkbox"/> Never
Do you have constipation?	<input type="checkbox"/> Always	<input type="checkbox"/> Seldom	<input type="checkbox"/> Never
Do you strain to have a bowel movement?	<input type="checkbox"/> Always	<input type="checkbox"/> Seldom	<input type="checkbox"/> Never
Do you have loose stools/diarrhea?	<input type="checkbox"/> Always	<input type="checkbox"/> Seldom	<input type="checkbox"/> Never
Do you have bowel urgency that is difficult to control?	<input type="checkbox"/> Always	<input type="checkbox"/> Seldom	<input type="checkbox"/> Never
Do you lose control of your bowels?	<input type="checkbox"/> Always	<input type="checkbox"/> Seldom	<input type="checkbox"/> Never
Do you have incomplete emptying?	<input type="checkbox"/> Always	<input type="checkbox"/> Seldom	<input type="checkbox"/> Never
Do you have pain <u>with</u> a bowel movement?	<input type="checkbox"/> Always	<input type="checkbox"/> Seldom	<input type="checkbox"/> Never
Do you have pain <u>after</u> a bowel movement?	<input type="checkbox"/> Always	<input type="checkbox"/> Seldom	<input type="checkbox"/> Never
Does it take longer than 5 minutes to have a bowel movement?	<input type="checkbox"/> Always	<input type="checkbox"/> Seldom	<input type="checkbox"/> Never
Do you have bloating (increased pressure in abdomen)?	<input type="checkbox"/> Always	<input type="checkbox"/> Seldom	<input type="checkbox"/> Never
Do you experience a physical change in abdominal girth when your bowels are full (distension)?	<input type="checkbox"/> Always	<input type="checkbox"/> Seldom	<input type="checkbox"/> Never

In your opinion, is your fibre intake  Too low  Adequate  Too high

Do you regularly use  Laxatives  Stool softeners  Natural products  Enemas

Have you ever been diagnosed with/think you have:

Irritable bowel syndrome	When? _____	Who? _____
Ulcerative colitis	When? _____	Who? _____
Crohn's Disease	When? _____	Who? _____
Celiac Disease	When? _____	Who? _____

Do you have any food allergies or sensitivities?

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## Medical History

Urinary tract infections?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How often?
Antibiotics recently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Last UTI?
Probiotics?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Cranberry supplementation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Smoking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	# packs/day
Chronic cough?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Do you get blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Allergies (including latex)			
Do you exercise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Type of exercise:			Frequency:
Low back problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chronic? <input type="checkbox"/> Yes <input type="checkbox"/> No
Mid back problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chronic? <input type="checkbox"/> Yes <input type="checkbox"/> No
Neck problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chronic? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been treated for depression?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	What treatment?
Is/was treatment effective?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever been treated for anxiety?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	What treatment?
Is/was treatment effective?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Have you ever been diagnosed with a mental health condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, what?

## Sexual History

Last PSA score:	When?	Last digital rectal exam:
Does your prostate get painful/irritated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Has your prostate fluid been expressed and tested?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have painful erections?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Can you achieve a satisfactory erection?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have premature ejaculation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have pain during intercourse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	When?

On a scale from 1-10, please circle and rate how much this problem bothers you

1      2      3      4      5      6      7      8      9      10

On a scale of 1-10, please circle and rate how motivated you are to correct this problem

1      2      3      4      5      6      7      8      9      10