CONFIDENTIAL PATIENT HISTORY FORM- PHYSIO

Name _____ **Birthdate** _____
(month/day/year)

Address _____ **Family Doctor** _____
_____ Phone _____
Postal Code _____ **Referring Professional** _____
Phone (home) _____ Phone _____
(work) _____
(cell) _____ Text Appointment Reminder? **Y/N** If yes, cell provider: _____
Email _____ Email Appointment Reminder? **Y/N**
Occupation _____
ICBC or WCB? ❑ No ❑ Yes
(if yes, please ask for extra forms)

How did you hear about physiotherapy? _____
How did you hear about our clinic? _____

Please indicate if you believe if any of the following apply to you? (P=past C=current) Circle if necessary.

__ Heart Attack
__ High / Low Blood Pressure
__ Stroke or Aneurysm
__ Pace Maker
__ Other Heart Condition
__ Varicose Veins
__ Bruise easily
__ Other Circulatory Condition

__ Diabetes
__ Kidney Disease
__ Other Urinary Condition

__ Headaches / Migraines
__ Dizziness / Fainting
__ Nausea
__ Spinal Injury
__ Head Injury
__ Epilepsy / other seizures
__ Other Neurological Conditions

__ Asthma
__ Chronic Sinusitis
__ Other Respiratory Condition

__ Irritable Bowel / Colitis
__ Digestive Condition
__ Skin Condition

__ Joint Dislocation
__ Bone Fracture
__ Arthritis
__ Osteoporosis
__ Rods / Pins / Plates / Shunts
__ Implants _____
__ Transplant _____
__ Corrective Lenses / Contacts

__ Cancer _____
__ Hepatitis
__ HIV
__ Other Contagious Condition
_____

Are you pregnant? ❑ Yes ❑ No
Please Comment: _____

Please list any Medications you presently take:

_____
_____

Known Allergies (including medications, foods, seasonal, oils and lotions, etc.)

_____

Do you have any family history of medical conditions? ❑ Yes ❑ No
Please List: _____

Have you ever been hospitalized, had any major accidents, illnesses, or surgeries? ❑ Yes ❑ No
Please Comment: _____
_____

Continued over…

Other therapy / treatment : (past or present, does not have to be related to this visit)

❑ Massage Therapy	Date of last visit	_____	Location	_____
❑ Chiropractor	"	_____	"	_____
❑ Physiotherapy	"	_____	"	_____
❑ Naturopath	"	_____	"	_____
❑ Acupuncture	"	_____	"	_____
❑ Other _____	"	_____	"	_____

List any Activities, Sports, Hobbies
(ie. Jogging, Hockey, Crafts, Computer, etc)

_____
_____
_____

List any **NON-prescription vitamins, minerals or other supplements** you are taking:

_____
_____
_____

Please CIRCLE the answer closest to how you PRESENTLY feel: (1 = poor, 5 = excellent)

Quality of Sleep	1	2	3	4	5
Energy Level	1	2	3	4	5
Eating Habits	1	2	3	4	5
Stress Level	1	2	3	4	5
Exercise Habits	1	2	3	4	5

Hours of sleep per night (approx) _____

Number of meals you regularly eat per day _____

Number of times you exercise per week _____

Smoker	Yes	No	Occasional
Alcohol	Yes	No	Occasional

Current Condition

Please describe your current condition & symptoms:

_____
_____
_____
_____

How long have you had this condition?

_____

How did it start? _____

_____

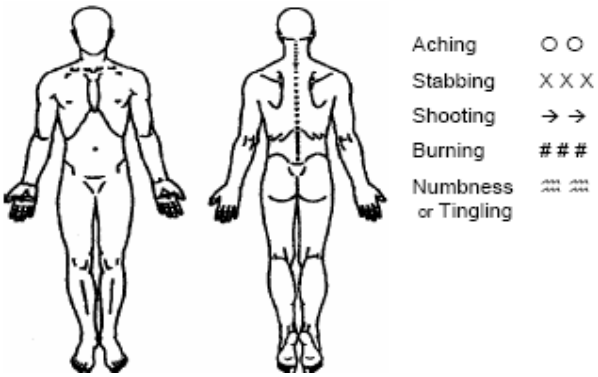
What aggravates it? _____

_____

What relieves it? _____

_____

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:



Patient Consent

PLEASE NOTE: If you are unable to keep an appointment with the physiotherapist, and have failed to give 24 hours notice, a cancellation fee may be charged.

I hereby acknowledge that all of the information herein is correct to the best of my ability:

Signature of Patient:_____ Date:_____
-or parent/guardian if under 19 years