PHYSIOTHERAPY HEALTH HISTORY FORM

An accurate health history is important to ensure that it is safe for you to receive treatments. If your health status changes, please let us know. All information collected is confidential, except as required or allowed by law or to facilitate diagnosis or treatment.

PERSONAL HISTORY

DATE: DD / MM / YYYY

FIRST NAME _____ LAST NAME _____

ADDRESS _____ CITY _____ POSTAL CODE _____ DD / MM / YYYY DATE OF BIRTH

( ) HOME PHONE ( ) MOBILE PHONE EMAIL ADDRESS _____

EMPLOYER INFORMATION

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ CITY _____ POSTAL CODE _____ ( ) WORK PHONE

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ Internet (Google, Website) ☐ Phone Book ☐ Massage Therapist ☐ Friend / Family _____

☐ Brochure ☐ Medical Doctor ☐ Personal Trainer ☐ Other _____

PREVIOUS PHYSIOTHERAPY ☐ YES ☐ NO

PHYSIOTHERAPISTS NAME _____ DD / MM / YYYY DATE OF LAST VISIT (APPROX.)

CLINIC NAME _____ **X-RAYS** ☐ **YES** ☐ **NO**

DO YOU WEAR FOOT ORTHOTICS ☐ YES ☐ NO

HOW LONG HAVE YOU WORN THEM? _____ HOW LONG SINCE LAST PAIR? _____

MADE BY _____

PRIMARY CARE MEDICAL DOCTOR

I authorize Target Therapeutics to send a report. ☐ **YES** ☐ **NO** **INITIAL** _____

DOCTORS NAME _____ CITY _____

MASSAGE THERAPIST

I authorize Target Therapeutics to send a report. ☐ **YES** ☐ **NO** **INITIAL** _____

THERAPISTS NAME _____ CLINIC NAME _____

PAST MEDICAL HISTORY (Please indicate conditions you are experiencing and/or experienced.)

GENERAL

☐ Numbness/Tingling ☐ Asthma
☐ Sinus Problems ☐ Cancer
☐ Loss of Sensation ☐ Fever
☐ Vision Loss ☐ Sweats
☐ Blurred Vision ☐ Fainting
☐ Eye Pain ☐ Diabetes
☐ Hearing Loss ☐ Allergies
☐ Earache ☐ Epilepsy
☐ Headache

MUSCLES & JOINTS

☐ Stiffness ☐ Shoulder Pain
☐ Weakness ☐ Osteoporosis
☐ Arthritis ☐ Upper Back
☐ Back Pain ☐ Low Back
☐ Neck Pain ☐ Mid Back
☐ Knee Pain ☐ Swollen Joints
☐ Arm Pain ☐ Other
☐ Leg Pain _____

RESPIRATORY

☐ Chronic Cough ☐ Emphysema
☐ Chest Pain ☐ Chronic Bronchitis
☐ Asthma

INFECTIONS

☐ Hepatitis ☐ Skin Conditions
☐ TB ☐ Other
☐ HIV _____

GASTROINTESTINAL

☐ Indigestion
☐ Nausea
☐ Diarrhea
☐ Colitis
☐ Poor Appetite
☐ Excessive Gas
☐ Constipation
☐ Ulcers

CARDIOVASCULAR

☐ Heart Disease
☐ Poor Circulation
☐ Swelling in Ankles
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Heart Attack
☐ Phlebitis
☐ Stroke/CVA
☐ Pacemaker
☐ Varicose Veins

Please specify any other medical conditions you may have that are not listed: _____

Special Note (presence of internal pins, wires, artificial joints, special equipment): _____

Had an accident? ☐ **YES** ☐ **NO** If **YES**, please describes: _____

Had an operation? ☐ **YES** ☐ **NO** If **YES**, please describes: _____

Had a fracture? ☐ **YES** ☐ **NO** If **YES**, please describes: _____

Been hospitalized? ☐ **YES** ☐ **NO** If **YES**, please describes: _____

Do you exercise regularly? ☐ **YES** ☐ **NO** If **YES**, how often: _____

MEDICATION / SUPPLEMENTS

☐ Anti-inflammatory ☐ Blood Pressure ☐ Other: _____
☐ Antibiotics ☐ Depression _____
☐ Cholesterol ☐ Pain Killers _____
☐ Anti-anxiety ☐ Blood Thinners _____
☐ Muscle Relaxants ☐ Vitamins/Herbs _____
☐ Antacids ☐ Essential Fats _____

STRESS LEVELS

☐ **LOW**
☐ **MODERATE**
☐ **HIGH**

PHYSIOTHERAPY HEALTH HISTORY FORM

CURRENT HEALTH CONDITION

Primary Complaint (Reason for coming in): _____

Other Doctors or Therapists for this condition: ☐ **YES** ☐ **NO** If **YES**, who treated you: _____

What was the treatment and result: _____ When did this condition begin: _____

Has it occurred before: ☐ **YES** ☐ **NO** If **YES**, when: _____ How many times: _____

Is it: ☐ Job Related ☐ Car Related ☐ Home Related ☐ Stress Related ☐ Injury ☐ Other: _____

Is the pain getting: ☐ Worse ☐ Better ☐ Constant ☐ Comes and Goes ☐ Other: _____

What aggravates your condition?

☐ Sitting ☐ Lifting ☐ Heat
☐ Standing ☐ Lying ☐ Cold
☐ Bending ☐ Walking ☐ Other: _____

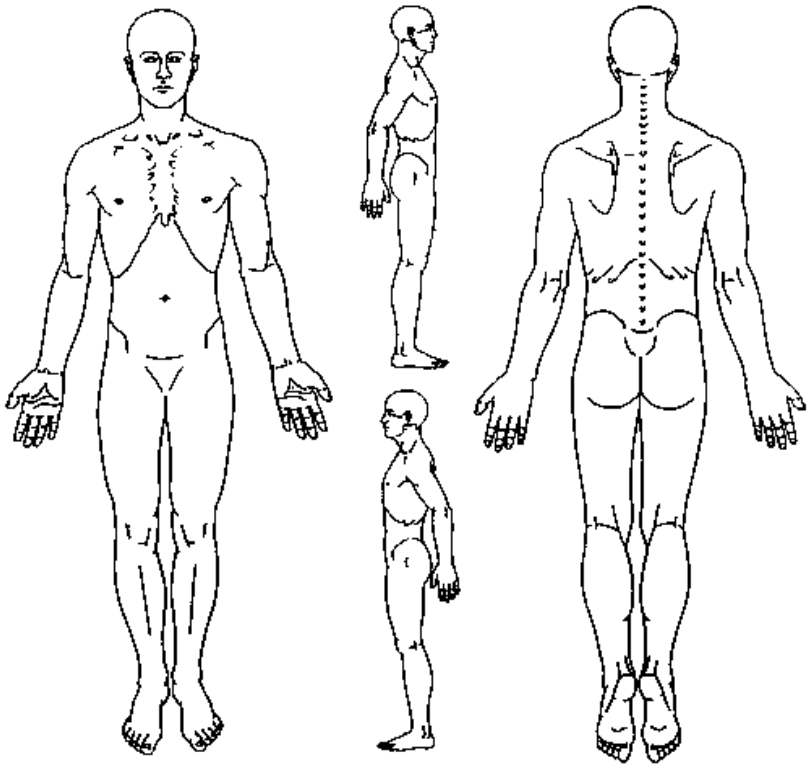
What makes you feel better?

☐ Sitting ☐ Lifting ☐ Heat
☐ Standing ☐ Lying ☐ Cold
☐ Bending ☐ Walking ☐ Other: _____

Please indicate the type(s) of pain you are feeling: ☐ Sharp ☐ Achy ☐ Numb ☐ Burning ☐ Tightness

Please circle the severity of your pain at this time: NO PAIN **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** WORST PAIN EVER

On the diagrams below use the symbol(s) and draw the location(s) of your pain: Sharp **O** Achy **X** Numb **+** Burning **^** Tightness **#**



INFORMED CONSENT

Physiotherapists treat pain originating from the musculoskeletal system of the human body. To do so physiotherapists perform examination procedures which may include orthopedic testing, palpation and neurological testing. Treatment may consist of soft tissue work, stretching, mobilization, manipulation and exercises. Adjunctive therapies such as T.E.N.S. interferential current and ultrasound and laser therapy may also be utilized.

The physiotherapist and staff will always be available to answer questions and concerns, and discuss the nature and purpose of the procedures.

I hereby request and consent to the performance of physiotherapy care. I understand that as in all health care certain risks may be associated with treatment, these including but not limited to, muscle strains/sprains, bruising and soreness. I do not expect the physiotherapist to be able to anticipate and explain all the risks and complications.

I wish to rely on the physiotherapist to exercise judgment during the treatment based on my best interests. I have the opportunity to ask questions about the above mentioned physiotherapy procedures.

I have read and understood the above information and by signing below I consent to the above mentioned procedures. I intend this consent to cover the entire course of care for my present conditioned and for future care that I may seek.

I hereby authorize Target Therapeutics to obtain and review copies of any hospital, medical or other related health records and give permission for valid related information to be discussed with and released to other health professionals, insuring agents or employers involved in my rehabilitation program.

_____ DD / MM / YYYY
FULL NAME (PLEASE PRINT) DATE

_____
PATIENT SIGNATURE