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 (For Appointment Reminders)

EMPLOYER INFORMATION

EMPLOYER | OCCUPATION

ADDRESS | CITY | POSTAL CODE | ( ) WORK PHONE

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ Internet ☐ Phone Book ☐ Massage Therapist ☐ Friend / Family _____

☐ Brochure ☐ Medical Doctor ☐ Postcard Mailer ☐ Other _____

PREVIOUS PHYSIOTHERAPY ☐ YES ☐ NO

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

CLINIC NAME

X-rays ☐ **YES** ☐ **NO**

OTHER PRACTITIONERS SEEN

MESSAGE THERAPY	☐ **Y** ☐ **N**	**DATE** _____
CHIROPRACTOR	☐ **Y** ☐ **N**	**DATE** _____
OSTEOPATHY	☐ **Y** ☐ **N**	**DATE** _____
ACUPUNCTURE	☐ **Y** ☐ **N**	**DATE** _____
OTHER _____	☐ **Y** ☐ **N**	**DATE** _____

PRIMARY CARE MEDICAL DOCTOR

I authorize Target Therapeutics to send a report.

☐ **NO** ☐ **YES** **INITIAL** _____

DOCTORS NAME | CITY

DO YOU WEAR FOOT ORTHOTICS ☐ YES ☐ NO

HOW LONG HAVE YOU WORN THEM? _____

HOW LONG SINCE YOUR LAST PAIR? _____

PHYSIOTHERAPY HEALTH HISTORY FORM

PAST MEDICAL HISTORY

GENERAL

- ☐ Numbness/Tingling
- ☐ Loss of Sensation
- ☐ Vision Loss
- ☐ Blurred Vision
- ☐ Hearing Loss
- ☐ Earache
- ☐ Headache
- ☐ Cancer
- ☐ Fainting
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fever
- ☐ Sweats
- ☐ Balance Problems

MUSCLES & JOINTS

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

GASTROINESTINAL

- ☐ 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
- ☐ Deep Vein Thrombosis
- ☐ Stroke/CVA
- ☐ Pacemaker
- ☐ Varicose Veins

INFECTIONS

- ☐ Hepatitis
- ☐ TB
- ☐ HIV
- ☐ Other _____

RESPIRATORY

- ☐ Chronic Cough
- ☐ Chest Pain
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic Bronchitis
- ☐ Sinus Problems
- ☐ Asthma
- ☐ COPD

- Please specify any other medical conditions you may have that are not listed: _____
- Presence of internal pins, wires, artificial joints, special equipment: _____
- Had an accident? ☐ **YES** ☐ **NO**
  If **YES**, please describe: _____
- Had an operation? ☐ **YES** ☐ **NO**
  If **YES**, please describe: _____
- Had a fracture? ☐ **YES** ☐ **NO**
  If **YES**, please describe: _____
- Been hospitalized? ☐ **YES** ☐ **NO**
  If **YES**, please describes: _____
- Have you had cancer? ☐ **YES** ☐ **NO**
  If **YES**, please describe: _____

MEDICATION / SUPPLEMENTS

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

STRESS LEVELS

- ☐ **LOW**
- ☐ **MODERATE**
- ☐ **HIGH**

PHYSIOTHERAPY HEALTH HISTORY FORM

CURRENT HEALTH CONDITION

Primary Complaint (Reason for coming in): _____

Has it occurred before: ☐ **NO** ☐ **YES** _____ 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: _____

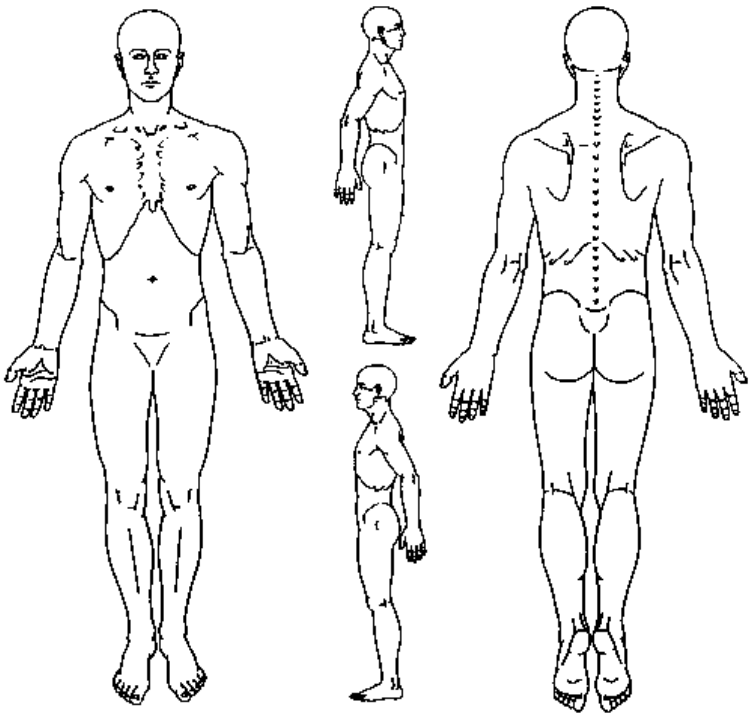
What makes you feel better?

☐ 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

_____

SIGNATURE