Date: ______________________

CONFIDENTIAL PHYSIOTHERAPY CASE HISTORY

Your answers will help us determine if our care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case but will work to refer you to the appropriate health care provider. If you need help with this form, please do not hesitate to ask us.

PERSONAL INFORMATION

Name: ❑ Mr. ❑ Mrs. ❑ Ms ❑ Miss ❑ Dr. ______________________

How do you wish to be addressed in our office? ❑ First Name ❑ Mr. ❑ Mrs. ❑ Ms ❑ Miss ❑ Dr.

Marital Status: ❑ M ❑ S ❑ W ❑ D

Address: ______________________ City: ______________________

Postal Code: ______________ Phone: ______________ Business Phone: ______________

Date of Birth: dd_____mm_____yr_____ e-mail address: ______________________

Employer: ______________________ Address: ______________________

Occupation: ______________ Hobbies: (What occupies your spare time?) ______________

Spouse's or Partner's Name: ______________________

Employer: ______________________ Telephone: ______________

How did you hear about our office? ______________________

Medical Doctor's Name: ______________________

I consent to the clinic to communicate electronically with me for the purpose of scheduling appointments, appointment confirmations, clinic updates and newsletters. ❑ Yes ❑ No

HEALTH INFORMATION

Have you ever been to a physiotherapist before? ❑ No ❑ Yes, Name: ______________

When was your last visit? __________ What was the problem? ______________________

Have you had previous healthcare for this problem? ❑ Yes ❑ No

Where? ______________ When? ______________________

Were x-rays taken? ______________________

REASON FOR CONSULTING OUR OFFICE

What is your major complaint? ______________________

Is this complaint a result of a motor vehicle accident? ❑ No ❑ Yes, Date: ______________

Is this a Workman's Compensation case? ❑ No ❑ Yes, Injury Date: ______________

How long have you had this condition? ______________________

____

Have you had this or similar conditions in the past? ❑ No ❑ Yes, and when? ______________

____

What activities aggravate your condition? ______________________

What makes it better? ______________________

Is this condition getting progressively worse? ❑ Yes ❑ No ❑ Constant ❑ Comes and goes______________

Is this condition interfering with your ❑ Work ❑ Sleep ❑ Daily Routine ❑ Other______________

(Please complete both sides)

Has there been any medical diagnosis of your complaint? ❑ No ❑ Yes, if yes list the Dr.'s name and diagnosis:

____

List surgical operations and years: ____

____

List any Prescription Drugs, Over the counter Drugs, Vitamins and Natural Supplements you are currently taking:

____

Do you wear: ❑ Heel Lifts ❑ Sole Lifts ❑ Inner soles ❑ Arch supports ❑ Orthotics

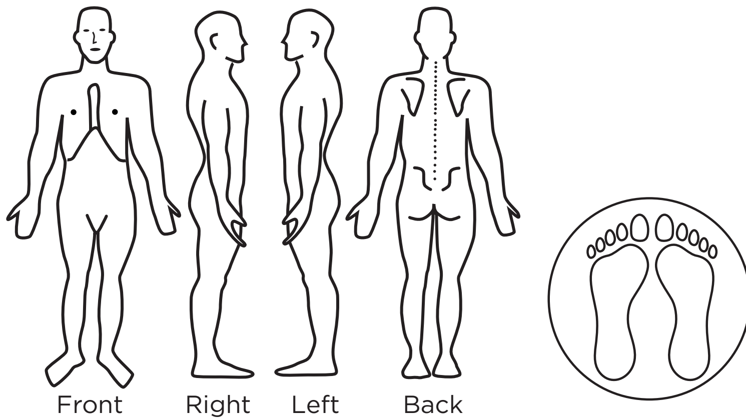
Have you had any other personal injury or accident: ❑ None ❑ Past year ❑ Past 5 years ❑ Over 5 years

Description of accident: ____

____

Date of most recent physical examination: ____

Please mark the areas of pain and/or discomfort on the figures below:



Please rate your current level of discomfort:

No Pain	Moderate Pain	Unbearable Pain

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Are you affected by any of the following? Please check ❑ O = Occasionally F = Frequently C = Constantly

General Symptoms:	**O**	**F**	**C**
Diabetes	❑	❑	❑
Excessive sweating	❑	❑	❑
Night Sweats	❑	❑	❑

Neurological:	**O**	**F**	**C**
Headache	❑	❑	❑
Fainting	❑	❑	❑

Muscles and Joints:	**O**	**F**	**C**
Arthritis/Rheumatism	❑	❑	❑

Skin:	**O**	**F**	**C**
Bruise easily	❑	❑	❑
Hives/Skin Allergies	❑	❑	❑

Cardiovascular:	**O**	**F**	**C**
Bleeding Disorder	❑	❑	❑
High Blood Pressure	❑	❑	❑
Low Blood Pressure	❑	❑	❑
Chest Pain	❑	❑	❑
Stroke	❑	❑	❑
Arteriosclerosis	❑	❑	❑
Varicose veins	❑	❑	❑
Swelling of ankles	❑	❑	❑
Angina	❑	❑	❑
Irregular Heart Beat	❑	❑	❑

ENT:	**O**	**F**	**C**
Ring/buzz in ears	❑	❑	❑

Respiratory:	**O**	**F**	**C**
Asthma	❑	❑	❑
Difficulty breathing	❑	❑	❑
Wheezing	❑	❑	❑

Lifestyle:	**O**	**F**	**C**
Smoker	❑	❑	❑
If yes, how long?	❑	❑	❑
If yes, how much?	❑	❑	❑
Drink Alcohol	❑	❑	❑
If yes, how much?	❑	❑	❑
Exercise	❑	❑	❑

For Women:	**O**	**F**	**C**
Excessive Flow	❑	❑	❑
Hot Flashes	❑	❑	❑
Absent/Irregular Cycle	❑	❑	❑
Cramping/Backache	❑	❑	❑
Pregnant	Yes ❑		No ❑

We thank you for your patience and cooperation in completely filling out this form.

Patient's Signature: ________________________________ Dated: ______________________

Patient consent for examination ________________

Physiotherapist's Initials