



**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**

Legal Name: \_\_\_\_\_

How do you wish to be addressed in our office? \_\_\_\_\_

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?) \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Medical Doctor's Name: \_\_\_\_\_

Would you like a medical report forwarded to your MD?  Yes  No

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 Workers' 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:

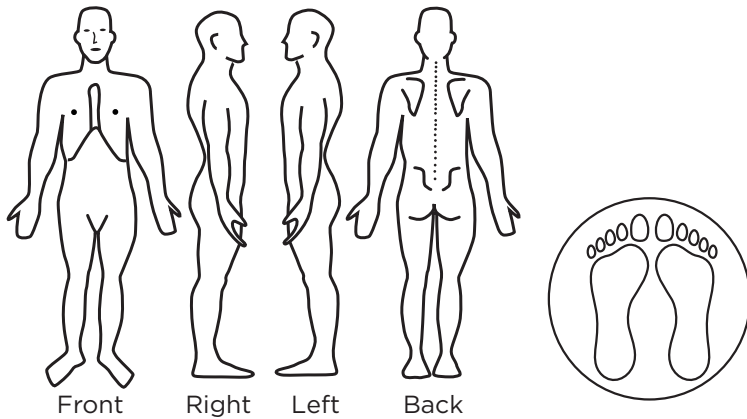
Do you wear:  Heel Lifts  Sole Lifts  Inner soles  Arch supports  Orthotics

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

|  |  |  |
|--|--|--|
| <p><b>General Symptoms:</b></p> <p>Diabetes <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p>Excessive sweating <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p>Night Sweats <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p><b>Neurological:</b></p> <p>Headache <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p>Fainting <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p><b>Muscles and Joints:</b></p> <p>Arthritis/Rheumatism <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p><b>Skin:</b></p> <p>Bruise easily <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p>Hives/Skin Allergies <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> | <p><b>Cardiovascular:</b></p> <p>Bleeding Disorder <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p>High Blood Pressure <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p>Low Blood Pressure <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p>Chest Pain <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p>Stroke <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p>Arteriosclerosis <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p>Varicose veins <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p>Swelling of ankles <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p>Angina <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p>Irregular Heart Beat <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p><b>ENT:</b></p> <p>Ring/buzz in ears <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p><b>Respiratory:</b></p> <p>Asthma <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p>Difficulty breathing <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p>Wheezing <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> | <p><b>Lifestyle:</b></p> <p>Smoker <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p>If yes, how long? <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p>If yes, how much? <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p>Drink Alcohol <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p>If yes, how much? <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p>Exercise <input type="checkbox"/> O <input type="checkbox"/> F <input type="checkbox"/> C <input type="checkbox"/> NA</p> <p><b>Gynecological Conditions:</b></p> <p>Describe: _____</p> <p>_____</p> <p>_____</p> <p>Pregnant?                      Yes <input type="checkbox"/>    No <input type="checkbox"/></p> <p>Due date: _____</p> |
|--|--|--|

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