CoreSolutions
PHYSIOTHERAPY AND WELLNESS

MEDICAL HEALTH HISTORY FORM

Please complete this questionnaire. All information will be kept strictly confidential.

PERSONAL INFORMATION

Name: _____

Address:_____City:_____Postal Code: _____

Telephone: (H) _____ (M) _____

Occupation:_____ EMAIL:_____

Date of Birth: _____ Age:_____

Marital Status:_____ Referred By:_____

Physician's Name / Address / Tel. No._____

_____

CURRENT HISTORY

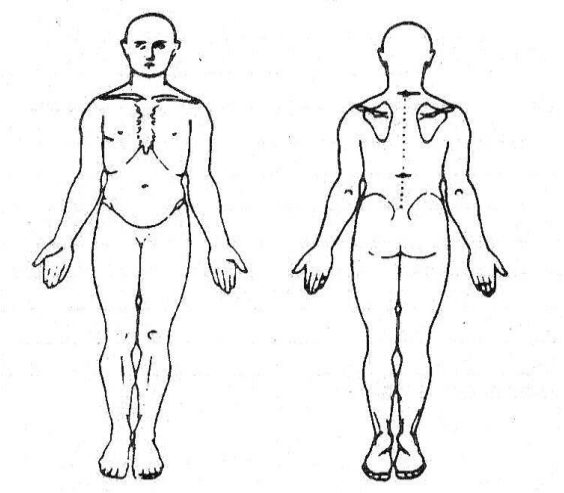
What are your most important priorities for this visit?

Have you been treated for this before? **Y** **N** If yes, by whom? _____

Imaging Results: (X-Rays, MRI, CT, Bone Scan, Ultrasound) _____

INDICATE CURRENT SYMPTOMS ON THE FIGURES

P = areas of pain
X = areas of joint stiffness
S = areas of numbness & tingling
= areas of scars, bruises & open wounds



Dominant Hand (circle one): **R** **L**

Any wires, pins, artificial limbs, special equipment? **Y** **N**

Exercise / Activities (when injury free) list activities, frequency, duration as well as goals:

_____

_____

How many days per week do you do cardio for at least 30 minutes? _____

Do you do any strength training? **Y** **N**

Do you think exercise is causing you to flare up? **Y** **N**

(please turn over)

MEDICATIONS / SUPPLIMENTS **NAME** **DOB**

List all prescription and non-prescription medications you are currently taking:

_____

Has your medication dosage changed recently? **Y N** Are you on Blood Thinners? **Y N**

Have you been on prednisone in the last year? **Y N**

Have you been treated with chemotherapy? **Y N** If yes, when? _____

Are you taking any vitamin / mineral / herbal supplements? **Y N** If yes, what? _____

LIFESTYLE HABITS

Do you have any food sensitivities or food allergies? **Y N**
If yes, what? _____

What is your primary source of daily protein intake? _____

Do you drink coffee? **Y N** If yes, how many cups / day?_____

Do you drink tea? **Y N** If yes, how many cups / day?_____

Do you drink milk? **Y N** If yes, how many cups / day?_____

Do you drink water? **Y N** If yes, how many cups / day?_____

How much alcohol do you drink / week? _____

Do you smoke? **Y N** If yes, how much? _____ For how many years?_____

How many hours of **actual** sleep do you get each night? **(circle one) less than 7 / 7-9 / 10-12**

Do you have trouble falling asleep? **Y N** If yes, why? _____

MEDICAL HISTORY – Do you have, or have you had, any of the following? (CIRCLE all that apply)

Lung	**Heart**	**Gastrointestinal**
Chronic Cough	Chest, Arm or Jaw Pain with Exercise	Difficult Digestion
Asthma	High Blood Pressure	Irritable Bowel
Shortness of Breath	Low Blood Pressure	Crohn's or Colitis Disease
Bronchitis	Poor Circulation	GERD (Acid Reflux)
Emphysema	Heart Attack	Gall Bladder Stones
Difficulty Breathing Exercise	Angina	Ulcer
	Pacemaker	Constipation (0-1 bowel movements daily)
Blood Vessels	Enlarged Heart	Diarrhea
Varicose Veins	Fainting	Bloating
Blood Clots (DVT)	Coronary Artery Disease	Bloody Stool
Leg Swelling	Stroke	Liver Problems (Hepatitis or Jaundice)
Arteriosclerosis	Anemia	
Kidney	**Hormonal**	**Skin**
Kidney Failure	Thyroid Condition (Hypo / Hyper)	Cellulitis
Kidney Stones	Adrenal Condition	Psoriasis
Pain with Urination	Diabetes	Hypersensitivity / Allergies
Bladder Infections		Bruise Easily

	NAME **DOB**	
Reproductive Organs	**Musculoskeletal**	**Neurologic**
Females:	Osteoporosis	Seizures
Menopause	Osteoarthritis	Multiple Sclerosis
Pregnant	Rheumatoid Arthritis	Concussion
Difficult Labour or Delivery	Ankylosing Spondylitis	Head Injury
Planning Children	Gout	Headaches
Infertility	Degenerative Disc Disease	Vision Problems
Ovarian Cysts	Low Back Pain	Hearing Problems
Endometriosis	Neck Pain	Earaches
Pelvic Pain	Middle Back Pain	Dizziness / Vertigo
	Shoulder Pain	
Males:	Fractures (broken bones)	**Mental**
Prostate Infection or Cancer	Leg Pain	Depression
Hernia	Knee Pain	General Anxiety
Testicular Pain / Cancer	Foot and Ankle Pain	Memory Loss
		Panic Attacks

Surgeries (list all surgeries, including C sections and the year of procedure):

_____

Cancer / Tuberculosis / HIV Infection / Other:

_____

What are your major stressors? ________

Family History: _____

HOW DID YOU HEAR ABOUT THE CLINIC? (circle one)

DOCTOR FAMILY/FRIEND INTERNET

SIGN ARTICLE/PUBLICATION OTHER_____

INFORMED CONSENT

IT IS MY CHOICE TO RECEIVE THERAPY AND I UNDERSTAND THAT THE TREATMENT THAT IS BEING GIVEN FOR THE WELL BEING OF MY BODY AND MIND. I AGREE TO COMMUNICATE WITH MY THERAPIST IF MY WELL BEING IS BEING COMPROMISED. I UNDERSTAND THAT THE THERAPIST WILL OUTLINE THE TREATMENT AND WILL COMMENCE ONCE CONSENT HAS BEEN OBTAINED. I UNDERSTAND THAT I MAY STOP TREATMENT ANYTIME I CHOOSE. I ACKNOWLEDGE THAT THERAPY IS NOT A SUBSITUTE FOR MEDICAL EXAMINATION OR DIAGNOSIS AND IT IS RECOMMENDED THAT I SEE A PHYSICIAN FOR THAT SERVICE.

SIGNATURE_____**DATE**_____

CANCELLATION POLICY:

Please inform clinic 24 hours to appointment. Repeat no shows will be charged $30