Date_____

Patient History Form

Name _____ Phone (_____) _____

Address _____ City _____ Prov _____ Postal Code _____

Birthdate _____/_____/_____ Gender: M / F Cell Phone (_____)_____

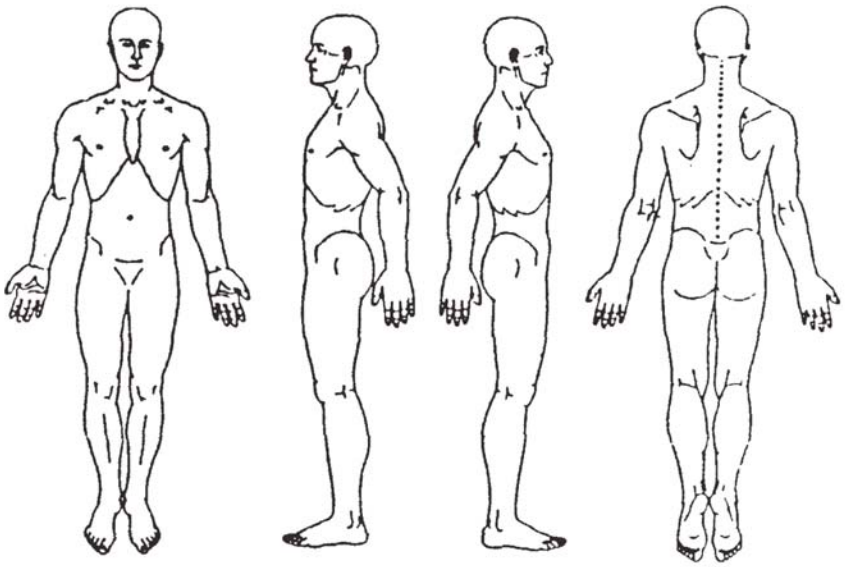
Emergency Contact _____ Phone (_____)_____ Relationship _____

Physician _____ Phone (____)_____

What is your chief complaint(s)? _____

Draw the area of your symptoms using these symbols:
(mark on the figures)

XXX = ache
✻ = sharp/stab
ooo = numb/tingle
⟶ = shooting
//// = stiff/tight



Pt. History 3.1
#1.04 SCSI©

How often are your symptoms present? □ Constantly □ Frequently □ Occasionally □ Intermittently

Is your current problem the result of: Auto Accident? □Yes □No Work Accident? □Yes □No

Date Problem began _____

List other treatments or tests you've had for this condition _____

Past medical history with dates (accidents, injuries, falls, surgeries) _____

_____

_____

Has this problem affected your daily life? (job/exercise/sport) _____

Current Medication _____

What are your goals and expectations of physiotherapy? _____

_____

_____

Patient Health Questionnaire

Patient Name _____

Please check all that apply. Knowledge of these conditions may influence the type of treatment/therapy you receive.

- □ Angina
- □ Anorexia
- □ Aortic Aneurysm
- □ Arthritis
- □ Asthma
- □ Bladder Infection
- □ Blood Disorder
- □ Breast Lump
- □ Cancer
- □ Chest Pain
- □ Chronic Cough
- □ Chronic Sinusitis
- □ Colitis
- □ Convulsions
- □ Diabetes
- □ Depression
- □ Digestive Disorders
- □ Dizziness
- □ Emphysema
- □ Epilepsy
- □ Fainting
- □ Headache
- □ Heart Disease
- □ Heartburn/Indigestion
- □ Hepatitis
- □ Herniated Disk
- □ High Blood Pressure
- □ Jaw Pain
- □ Liver/Gallbladder Problems
- □ Kidney Disorders
- □ Loss of Bladder Control
- □ Nervousness
- □ Pacemaker
- □ Pain - Neck
- □ Pain - Mid Back
- □ Pain - Low Back
- □ Pain - Arm/Elbow
- □ Pain - Hand
- □ Pain - Wrist
- □ Pain - Shoulder
- □ Pain - Ankle or Foot
- □ Pain - Leg
- □ Pain - Knee
- □ PMS
- □ Prostate Problems
- □ Rapid Heartbeat
- □ Rheumatic Fever
- □ Pregnancies
- □ Scoliosis
- □ Stroke
- □ Swelling, Stiffness of Joints
- □ Tinnitus (Ear Noises)
- □ Tuberculosis
- □ Ulcer
- □ Vision Disturbances
- □ Venereal Disease
- □ Other _____

Height: _____ feet _____ inches

Weight: _____ pounds

<u>For all patients over 19 yrs. old</u>:

- □ Smoking - Packs/Day_____
- □ Alcohol - Drinks/Week _____
- □ Coffee/Caffeine Drinks - Cups/Day _____
- □ Alcohol Dependence
- □ Drug Dependence

Please list all allergies including allergies to medications

_____

List all medications you are presently taking (including vitamins & supplements)

_____

List any surgeries, fractures, serious illnesses or hospitalizations

_____

<u>Family Health History</u>:

If a <u>family member</u> has had any of the following, please mark the appropriate box:

□ Cancer □ Diabetes □ Heart Problems □ High Blood Pressure □ Chronic Headaches
□ Epilepsy □ Lupus □ Lung Problems □ Chronic Back Problems □ Rheumatoid Arthritis
□ Alcoholism Other _____

I certify that all the above personal health information, on pages one and two, is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition in the future.

Patient or Guardian Signature _____ Date _____