

CONFIDENTIAL PATIENT HISTORY FORM- PHYSIO

Name		Birthdate				
Address		Family Doctor	(month/day/year)			
	- · · · · · · · · · · · · · · · · · · ·		Phone			
Phone	Postal Code(home)	Referring Profe	Phone			
Email Occupat	(work) (cell)	Email Appointme	Text Appointment Reminder? Y/N If yes, cell provider: Email Appointment Reminder? Y/N ICBC or WCB? □ No □ Yes			
-	you hear about physiotherapy?you hear about our clinic?		(if yes, please ask for extra forms)			
Please ir	ndicate if you believe if any c	owing apply to you?	(P=past C=current) Circle if necessar	y.		
	_ High / Low Blood Pressure _ Stroke or Aneurysm _ Pace Maker _ Other Heart Condition	aches / Migraines less / Fainting lea I Injury Injury lesy / other seizures Neurological Conditions lea lic Sinusitis Respiratory Condition le Bowel / Colitis live Condition Condition	Joint Dislocation Bone Fracture Arthritis Osteoporosis Rods / Pins / Plates / Shunts Implants Transplant Corrective Lenses / Contacts Cancer Hepatitis HIV Other Contagious Condition			
Are you	pregnant? ☐ Yes ☐ No Please Comment: _					
Please li	st any Medications you pres					
Known A	Allergies (including medication	seasonal, oils and lotions, et				
Do you h	nave any family history of me Please List:					
Have you	u ever been hospitalized, had Please Comment:					

Chiropischer	Other therapy / trea					s not have last visit	e to be related to this visit) Location		
Naturopath Acquincture Other Ist any Activities, Sports, Hobbles (ie. Jogging, Hockey, Crafts, Computer, etc) List any NON-prescription vitamins, minerals or other supplements you are taking: Please CIRCLE the answer closest to how you PRESENTLY feel: (1 = poor, 5 = excellent) Quality of Sleep	☐ Chiropractor☐ Physiotherapy☐ Naturopath☐ Acupuncture					II .			
□ Acupuncture □ Other □ Other □ Other □ Other □ Chief						"	"		
List any Activities, Sports, Hobbies (ie. Jogging, Hockey, Crafts, Computer, etc) List any NON-prescription vitamins, minerals or other supplements you are taking: Please CIRCLE the answer closest to how you PRESENTLY feel: (1 = poor, 5 = excellent) Quality of Sleep 1 2 3 4 5 Hours of sleep per night (approx) Earling Habits 1 2 3 4 5 Number of meals you regularly eat per day Stress Level 1 2 3 4 5 Number of times you exercise per week Smoker Yes No Occasional Alcohol Yes No O						-			
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Eating Habits 1 2 3 4 5 Stress Level 1 2 3 4 5 Stress Level 1 1 2 3 4 5 Number of times you exercise per week Smoker Yes No Occasional Alcohol Yes No Occasional Current Condition Please describe your current condition & symptoms: Please indicate on the diagram the nature of your symptoms, using the symbols indicated: Aching O Stabbing XXX Shooting → → Burning ### Numbness or Tingling ### What aggravates it? What relieves it? Patient Consent PLEASE NOTE: If you are unable to keep an appointment with the physiotherapist, and have failed to give 24 hours notice, a cancellation fee may be charged. I hereby acknowledge that all of the information herein is correct to the best of my ability: Signature of Patient: Date: Date:									
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							Date:		