VAUGHAN PHYSIOTHERAPY CLINIC

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Medical Health History: Please fill in the following information as accurately as possible. Let us know if you require any assistance.	
What are the goals you plan to achieve from visiting us:	
Have you received any of the following therapies?	☐ **Physiotherapy** ☐ **Chiropractic** ☐ **Massage Therapy** ☐ **Other**
Please list the previous type of treatment, body part, and year of treatment.	
Pain scale (within the past 24 hours)	☐**0** ☐**1** ☐**2** ☐**3** ☐**4** ☐**5** ☐**6** ☐**7** ☐**8** ☐**9** ☐**10** **(No Pain)** **(Extreme Pain)**

Head/Neck:

☐ Headaches ☐ Migraines ☐ Vision Loss/Change ☐ Double Vision ☐ Dizziness ☐ Eye Pain
☐ History of Fainting ☐ Hearing Loss/Ear Condition ☐ Nausea ☐ Other

Do you have and family history of the above?
☐ Yes ☐No

Pelvic Health

☐ Urinary/Bowel Incontinence
*Women only ☐ Gynecological Conditions ☐ Currently Pregnant

History of Pregnancies:

Other pelvic health concerns:

Cardiovascular:

☐ High Blood Pressure ☐ Low Blood Pressure ☐ Arteriosclerosis ☐ Chronic Congestive Heart Failure
☐ Heart Attack ☐ Stroke/CVA ☐ Heart Disease ☐ Phlebitis/Varicose Veins ☐ Blood Clots
☐ Pacemaker (or similar) ☐ Easy Bruising ☐ Other

Respiratory

☐ Chronic Cough ☐ Shortness of Breath ☐ Bronchitis ☐ Asthma ☐ Emphysema
☐ Chest Pain ☐ Other

Do you have and family history of the above?
☐ Yes ☐No

Neurological

☐ Multiple Sclerosis ☐ Muscular Dystrophy ☐ Parkinson's ☐ Numbness/Loss of Sensation
☐ Tremors ☐ Epilepsy/Seizures ☐ Other

Do you have and family history of the above?
☐ Yes ☐No

Communicable

☐ Hepatitis ☐ Skin Conditions ☐ TB ☐ HIV/AIDS ☐ Haemophilia ☐ Herpes ☐ Other

Do you have and family history of the above?
☐ Yes ☐No

Bone Health

☐ Osteoporosis/Osteopenia ☐ Arthritis

History of Fracture (please specify):

Do you have and family history of the above?
☐ Yes ☐No

Other Conditions

☐ Mental Health Concerns ☐ Diabetes ☐ Digestive Conditions ☐ Thyroid Disease
☐ Organ Dysfunction (e.g. kidney, liver, etc.)

Do you have and family history of the above?
☐ Yes ☐No

Allergies/Hypersensitivity (please specify):

Cancer (please specify):

- Date of last check up with oncologist: _____

Additional Questions

Have you had and significant weight loss/gain?
☐ Yes ☐No

Have you had any previous surgeries?
☐ Yes ☐No

Type of surgery:

Do you have any internal pins, wires, artificial joints or special equipment?

☐ Yes ☐ No

If yes, please specify:

Have you had any previous injuries?

☐ Yes ☐ No

If yes, please specify:

Have you ever been hospitalized?

☐ Yes ☐ No

Please list any current medications, vitamins/supplements not mentioned above:

Do you smoke?

☐ Yes ☐ No

If yes, how long?

If yes, how many packs per day?

Do you consume alcohol?

☐ Yes ☐ No

If yes, how many drinks per week?

Are you currently receiving treatment from another health care provider?

☐ Yes ☐ No

If yes, please specify: