



CONFIDENTIAL PATIENT INFORMATION SHEET

PERSONAL HISTORY

Name: _____ Date of birth: __/__/__ (MM/DD/YY) Age: _____ M / F

Address: _____ City: _____ Postal code: _____

Tel: Home _____ Business or Cell (*circle*) _____

Email: _____

Emergency contact (Name, Tel. & Relationship): _____

Name of Medical Doctor: _____ Tel: _____

Have you had a physical in the last year? Yes No

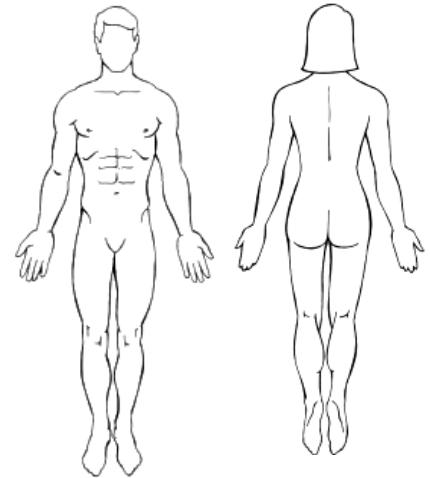
WSIB or MVA case? Yes No

How were you referred to this clinic? Friend: _____ Trainer: _____ Medical doctor
 Website Advertisement Other: _____

CURRENT HEALTH HISTORY

Current complaint(s) and when they started – in order of importance

- 1) _____
- 2) _____
- 3) _____



On the drawings to the right mark all painful areas with an **X**

Describe the pain:

- Sharp & stabbing Burning Pins & needles
- Dull ache Numb Stiff & tight

Please check those activities below during which you experience difficulty or pain:

- Laying on back Dressing self Reaching Standing for long periods Sitting
- Laying on side Pushing Kneeling Bending forward Sneezing
- Turning over in bed Pulling Stooping Bending backward Coughing
- Laying flat on stomach Sexual activity Walking Getting in/out of car Other _____

What movements/activities make it worse? _____

What movements/activities make it better? _____

Have you had this injury before? No Yes If yes, when? _____

Have you had previous therapy? No Yes If yes, with who? _____

Rate the following by circling a number:

Level of Pain now	None	0	1	2	3	4	5	6	7	8	9	10	Worst
Level of Pain at its worst	None	0	1	2	3	4	5	6	7	8	9	10	Worst
General level of Stress	None	0	1	2	3	4	5	6	7	8	9	10	Severe
Level of Physical activity	Inactive	0	1	2	3	4	5	6	7	8	9	10	Very active

Goals of seeking Therapy:

Type of exercise and activity you are involved in: _____

List any **medications, supplements** (vitamins, etc) you are currently taking: _____

Are you currently experiencing any ongoing medical conditions? _____

Number of meals you eat per day: _____ Are there any foods you avoid? _____

Do you wear Orthotics? No Yes If Yes, how long have you had them? _____

Are you a smoker? No Yes If Yes, _____ cigarettes/day for _____ years

Do you drink alcohol? No Yes If Yes, _____ glasses per week

Sleep: Hours per night _____

FEMALES ONLY: Are you pregnant? No Yes Last menstruation date: _____

FAMILY HEALTH HISTORY

Have you or anyone in your family had any of the following (specify whom):

Heart disease _____ High blood pressure _____

Cancer _____ Diabetes _____

Stroke _____ Other diseases _____

PAST HEALTH HISTORY

List any previous **Surgeries** and the year(s) they occurred

_____ Year _____ Year _____

List any previous **Fractures** and the year(s) they occurred

_____ Year _____ Year _____

List any previous **Accident / traumas** and the year(s) they occurred

_____ Year _____ Year _____