



CONFIDENTIAL PATIENT INFORMATION SHEET

The Urban Athlete
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PERSONAL HISTORY

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

Address: _____ City: _____ Postal code: _____

Tel: Home _____ Business _____ Cell _____

Email: _____

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

Name of Medical Doctor: _____ Tel: _____

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

Are you currently exercising? Yes No

Do you train with a personal trainer? No Yes _____
(name and location)

How were you referred to our clinic? _____

Is this related to a motor vehicle accident (**MVA**)? Yes No

CURRENT HEALTH HISTORY

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

1) _____

2) _____

3) _____

When did it start? _____

Rate your pain (None) 1 2 3 4 5 6 7 8 9 10 (Worst)

Does the pain travel/move? _____

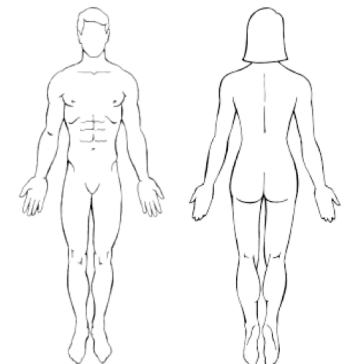
What makes it worse ?(eg. Movement, time of day, stress) _____

What makes it better? _____

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

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

Mark on the diagram where it hurts.



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

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |
| 4. _____ | 8. _____ |

List any medical conditions you have been diagnosed with (e.g. diabetes, heart disease, cancer, etc.)

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

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

How much sleep do you get per night? _____

FAMILY HEALTH HISTORY

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

- | | |
|--|--|
| <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> High blood pressure _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> 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 _____