Confidential Patient Health Record

Patient information

Date: _____/_____/_____

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Telephone: Home _____ Work _____

Cell: _____ Email: _____

Date of birth (dd/mm/yy) _____/_____/_____ Age: _____ Marital Status: S M C D W

Number of children: _____ Age of children: _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Relationship to contact: _____

Name of Medical Doctor: _____

Address: _____ May we contact your doctor? Y / N

Date of last visit to your medical doctor: ____/____/____ Date of last dental exam: ____/____/_____

Have you ever been to a physiotherapist before? Y / N Where?_____

For what condition?_____ Results?_____

Last appointment _____ Reason for leaving?_____

Are you coming here regarding an injury from a recent motor vehicle accident? Y / N or a workplace accident/injury? Y / N. If yes , Date:_____

How did you hear about the clinic? Internet___ Ad__ Doctor ___ Other ___ Friend(name) _____

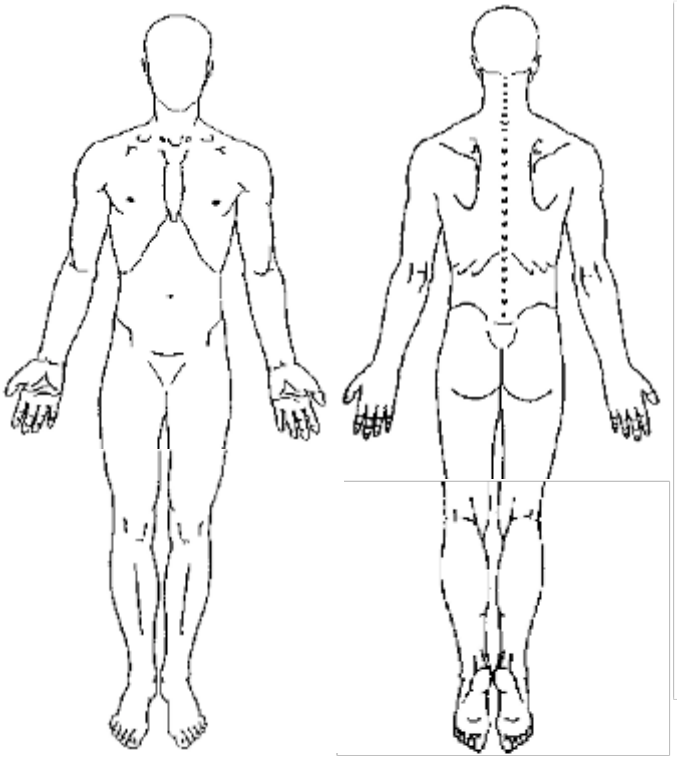
Personal information collected, used, stored and disclosed by this medical practice is confidential information.
24hrs notice is required to cancel or change appointments otherwise full charges apply.

Patient Name: _____ Date: _____

Current health condition

Purpose of this appointment: _____
_____

What is your goal in coming to this clinic? _____
_____



Draw in your face.

Mark the areas on the bodies where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness:	●●●● ●●●●
Pins and Needles:	0000 0000
Burning:	XXXX XXXX
Aching:	vvvvvv vvvvvv
Sharp/Stabbing:	/ / / / / / / / / / / /
Stiffness:	##### #####

Doctors only

Init: _____

On a scale of 0 to 10 (10 being the worst pain that you have ever felt), how would You rate your pain: At best: ____At worst: ____Usual:_____

When did this condition begin? _____
Anything associated with the onset? _____
_____

What increases the pain?

_____
_____
_____

What decreases the pain?

_____
_____
_____

Previous treatment for these complaints? _____
_____

Since it started, is your condition the **Same / Better / Worse**? Please circle.
Do you have any other problems with bones / joints / muscles?
Please describe _____
_____
_____

Patient Name: _____ Date:_____

Past Health history

Medical problems / hospitalizations / treatment:_____

Previous surgeries:_____

Surgeries recommended but not performed:_____

Current medications / vitamins:_____

Allergies to drugs / medications:_____

Any previous fractures? _____

Do you suffer from frequent or intense headaches? Y / N

Do you have a history of unexplained weight loss or weight gain? Y / N

Have you been diagnosed with any of the following (please circle all that apply):

IBS Chron's Psoriatic arthritis Rheumatoid arthritis Osteoarthritis Fibromyalgia
High Cholesterol High Blood pressure Heart Attack Angina Heart Surgery Diabetes
Stroke Deep vein thrombosis Blood Clotting Disorder TIA Cancer Gout

Lifestyle Habits

Do you smoke? Y/ N How many per day? _____ #of years _____ Have you ever smoked? Y / N
If yes, when did you quit? _____ How much did you smoke? _____ # of years _____

Do you consume alcohol? Y / N How many drinks per week?_____

Do you drink coffee? Y / N #cups per day? _____ Do you drink pop/soda? Y / N # per day _____

Rate your diet: Poor Fair Medium Good Excellent

Any trouble sleeping? Y / N If yes, reason _____

Do you exercise regularly? Y / N Types of exercise frequently performed:

_____

Health and wellness screening questionnaire

Do you have any skin problems? Describe._____

Do you have any nerve/psychiatric/psychological problems? Describe.

_____

Do you have any problems with your eyes/ears/nose/throat? Describe.

_____

Do you have any respiratory problems (asthma, bronchitis)? Describe.

_____

Do you have any digestive problems (ulcer, irritable bowel, indigestion, constipation, hiatus hernia)? Describe._____

Do you have any urinary system problems (recurrent infection, prostate, kidney problems)? Describe. _____

Questions for women only

Has your doctor ever indicated that you have osteoporosis? Y / N Does it run in your family? Y/ N

Have you had a bone density test in the past two years? Y / N . If yes, results?_____

Are you pregnant or planning pregnancy? Y / N

Do you have any problems with your breasts, menstrual cycle, Menopause? Y / N
if yes, please describe _____

Consent for Assessment and Treatment

1. I, _____ consent to an examination and treatment performed by a licensed physiotherapist. The results of the examination will assist the physiotherapist in determining the appropriate treatment(s) to meet my specific needs and goals.
2. I understand that my treatment in this clinic will involve physiotherapy techniques that may include, but are not limited to: manual techniques, spinal manipulation, electrotherapeutic modalities, acupuncture, trigger point dry needling (TDN) and exercise.
3. I acknowledge that the purpose of care and the risks of the recommended physiotherapy treatment techniques have been fully explained to and understood by me.
4. I understand that discomfort may occur following treatment. The therapist will contact my physician should the presence of symptoms represent any potential risks. I understand that it is my responsibility to contact a therapist in the clinic should I experience any unusual symptoms.
5. I understand that the Clinic will send an initial assessment and follow-up report(s) as appropriate to the licensed practitioner who referred me to the clinic for treatment.
6. I acknowledge that should I have concerns or questions about any recommended treatment, I will inform the therapist immediately so rationale for treatment and/or adjustments to my treatment can be made.
7. I agree to cooperate fully and to participate in all physiotherapy procedures, to comply with the plan of care as it is established. If I choose not to participate, I will inform the physiotherapist immediately.
8. I agree to pay clinic charges for the physiotherapy assessment and/or treatment upon my receipt of clinic invoices.
9. I acknowledge that no guaranties have been or can be made regarding the likelihood of success or outcome of any therapy.
10. I agree to inform my physiotherapist of any contagious or infectious conditions that I might have.
11. I have read the above and I certify that I have had an opportunity to discuss the contents thereof to my satisfaction. By signing below, I am hereby consenting to the physiotherapy care described above, to be performed by the physiotherapist or other members of the clinic's professional staff, as determined by the physiotherapist from time to time.

Name (print):_____ Signature:_____ Date:_____

*Parent/Guardian name and signature if patient under age of 16

I request that a copy of my initial assessment be sent to my family Dr.: ***(YES)*** *or* ***(NO)***

I request that a copy of my assessment be sent to my specialist: ***(YES)*** *or* ***(NO)***