

**PHYSIOTHERAPY & OCCUPATIONAL THERAPY SERVICES
PATIENT INFORMATION FORM**

Please fill out this questionnaire so that we may know more about your general health before assessing your present problem.

1. Please indicate any of the following conditions that **you** have:

	YES	NO		YES	NO
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid condition	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness/fainting	<input type="checkbox"/>	<input type="checkbox"/>	Smoking history	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Raynauds	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to chlorine	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Vision difficulties	<input type="checkbox"/>	<input type="checkbox"/>
History of cancer	<input type="checkbox"/>	<input type="checkbox"/>	Swallowing difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Allergies to tape/latex	<input type="checkbox"/>	<input type="checkbox"/>	Slurred Speech	<input type="checkbox"/>	<input type="checkbox"/>
Any Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Memory Problems	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Balance Problems	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Recent falls/blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Groin Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>
Other respiratory condition	<input type="checkbox"/>	<input type="checkbox"/>	Bowel & Bladder Difficulties	<input type="checkbox"/>	<input type="checkbox"/>
Hearing impairment	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		
Metal implants (including IUD)	<input type="checkbox"/>	<input type="checkbox"/>	Present Height : _____		
			Present Weight: _____		

SURGERIES: (please list) _____

Dates: _____

INJECTIONS: (please list) _____

Dates: _____

2. Is there anything else we should know about your health? _____

3. Do you have a return appointment with the doctor who referred you? YES NO

If yes, when ? _____

4. Are you employed? YES NO What is your occupation? _____

Full Duties Modified duties

5. What do you hope to achieve from therapy? _____

6. Are you **presently** receiving any of the following treatment:

- chiropractic massage occupational therapy naturopathic
 reflexology acupuncture physiotherapy podiatry/chiroprody

7. Please list any medications you are currently taking.

MEDICATION	DOSE	HOW OFTEN

8. Have you had any of the following tests for the condition for which you were presently referred?

TEST	YES	NO	WHEN	LOCATION OF TEST	RESULTS (If known)
X-rays					
CT scan					
EMG/nerve conduction					
MRI					
Bone density study					
Ultrasound					
Other (specify) _____ _____					

9. Name of your family physician: _____

10. Are you agreeable to having information related to your progress and discharge in therapy provided to your family physician and/or referring physician? YES NO

SIGNATURE (patient or parent/guardian)

DATE