Yarmouth Physiotherapy Inc.

2A Second St., Yarmouth, NS, B5A 1T2
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Client Medical Information

Do you or have you ever been diagnosed with any of the following:

	No	Yes		No	Yes
Arthritis	□	□	Dizziness / fainting / nausea	□	□
Osteoporosis (thin / brittle bones)	□	□	Vision problems	□	□
Frequent headaches/migraines	□	□	Hearing problems	□	□
Diabetes	□	□	Pain that wakes you at night	□	□
High blood pressure	□	□	Numbness in arms or legs	□	□
High Cholesterol	□	□	Numbness in seat / buttock	□	□
Pacemaker	□	□	Numbness in the face area	□	□
Heart/Circulation Problems	□	□	Blood disease (haemophilia, HIV)	□	□
Stroke/TIA (mini stroke)	□	□	Blood clot	□	□
Lung problems / Short of Breath	□	□	Bowel / Bladder problems	□	□
Are you presently a smoker?	□	□	Previous or current cancer	□	□
Epilepsy	□	□	Mental health problems	□	□
Change in energy levels	□	□	Allergies to latex or adhesives	□	□
Recent weight gain / loss	□	□	Female: Are you or could you be pregnant?	□	□
Night sweats	□	□			

Any other major health problems: ______________________________

INFORMATION ABOUT YOUR PRESENT PROBLEM:

What is your main complaint? ______________________________

What caused your complaint? □ Injury □ Do not know □ Other

If injury or other please describe: ______________________________

When did this problem begin? ______________________________

Is it: □ Getting better □ Worsening □ Staying the same

Level of pain (please circle one): No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain ever

Is your pain: □ Constant □ Intermittent □ Sharp □ Dull □ Tingling □ Numbness

What makes the pain better? ______________________________

What makes the pain worse? ______________________________

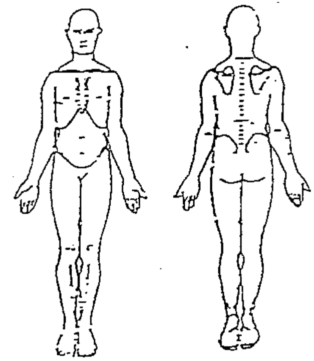
At what point in the day are your symptoms the worst: □ Morning □ Mid-day □ Night □ No change

Is this problem affecting any of your daily activities (describes): ______________________________

____

Please complete both sides of the form (see back)

Mark the area(s) of pain and/or numbness on the body diagrams below:



What recreational / leisure activities do you do? ___

Have you had any major surgery? □ No □ Yes ___

Any metal implants? (Pin/rod/plate/joint replacement, etc.) ___

Have you had any motor vehicle accidents in which you were hurt?

□ No □ Yes When: ___

Are you involved in legal action to do with your present injury? □ No □ Yes

What other health professionals are you seeing for this problem? ___

___

Describe any past/present treatment for this problem? ___

___

Have you had diagnostic imaging (X-Ray, MRI, CT scan...) or Lab work for this problem? ___

___

List all medications and supplements you are taking: ___

___

Client Consent

Please sign and date below if you consent to assessment and treatment by the physiotherapist, and the sharing of information with your other health professionals (Family physician, specialist...). Treatments will be explained to you and you can refuse any treatment.

Yarmouth Physiotherapy Inc has a 24 hour cancellation policy. Insurance companies/WCB do not pay for missed/cancelled appointments and the client may be subject to a charge. If you arrive late for your appointment your therapist may not be able to provide a full treatment.

Signature: ___ Date: ___

For Office Use Only:

□ Reviewed medical information sheet with the client.

___ ___

Date: (DDMMYYYY) Therapist's Signature