Medical History

Name:_____ **D.O.B.:**_____
Reason(s) for seeking therapy: _____
Date :_____

PRESENT INVOLVMENT IN ANY OTHER HEALTH CARE

☐ Massage ☐ Acupuncture ☐ Alternative therapies ☐ Other:_____

SOFT TISSUE AND JOINT (Problem Areas)

□ Shoulder	□ Elbow	□ Muscle weakness	□ Muscle soreness
□ Hand	□ Knee	□ Feet	□ Ankle
□ Spine	□ Other:_____		

HEALTH HISTORY – Please indicate conditions you are experiencing or have experienced.

□ Cancer	□Pace Maker	□Pregnancy*	□ Chest Pain
□ Rheumatoid Arthritis	□ Osteoarthritis	□ Osteoporosis	□ Scoliosis
□ Fractures	□ C.V.A/ Stroke	□Angina	□ Hypertension
□ Hypotension	□Circulatory Disorders	□ Diabetes	□ Asthma
□ Thyroid disorders	□ Chronic Cough	□ Breathing Disorders	□Artificial joint
□ Pins/Plates/Needles	□ Tuberculosis	□Epilepsy	□ Dizziness
□Cosmetic Implants	□ Bruises Easily	□ HIV/Aids	□ Hepatitis
□Hearing/Vision Loss	□ Multiple Sclerosis	□ Loss of Sensation	□ Arthritis

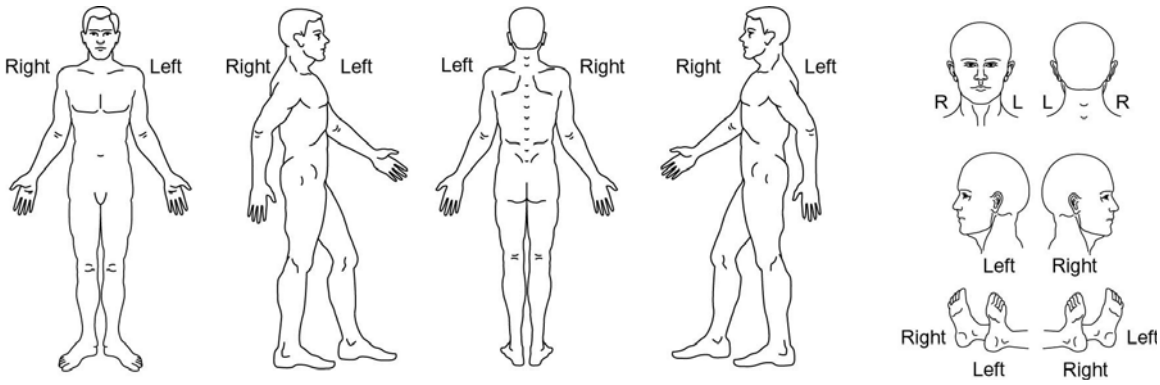
□Other_____

if you become pregnant during the course of physiotherapy treatment, please inform your treating therapist immediately

PAST SURGERIES OR INJURIES/ADDITIONAL COMMENTS /CONCERNS

_____
_____

Please mark which area(s) are affected:



Medical History

Please rate your pain: (no pain) 0__1__2__3__4__5__6__7__8__9__10 (worst possible pain)
Is this pain constant: ___ Yes, No___, How often does it occur? _____