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	☐ Neck	☐ Knee L/R	☐ Muscle soreness
☐ Elbow	☐ Spine/Back	☐ Ankle	☐ Muscle weakness
☐ Hand	☐ Legs	☐ Feet	☐ 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_____

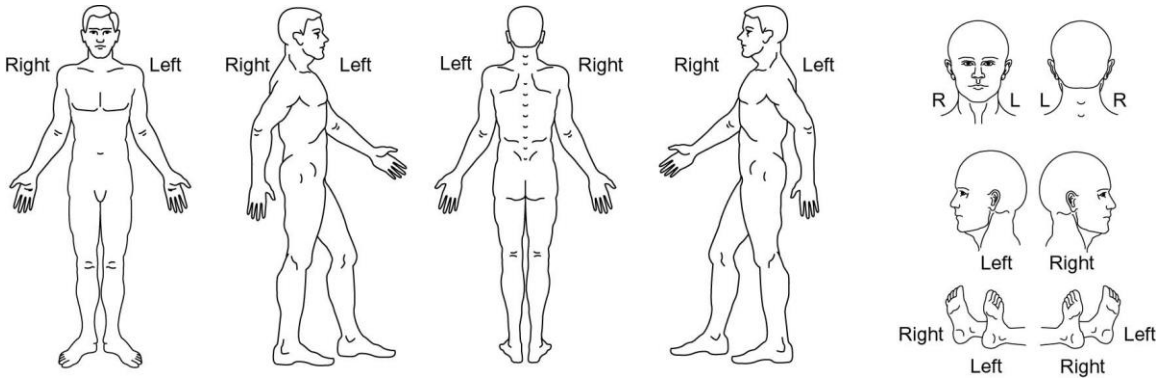
if you become pregnant during the course of physiotherapy treatment, please inform your treating therapist immediately

PAST SURGERIES OR INJURIES/ADDITIONAL COMMENTS /CONCERNS

_____

_____

Please mark which area(s) are affected:



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? _____