PHYSIOTHERAPY

newleaf
total wellness centre

Confidential Patient History

Please complete the following mandatory questionnaire. Your answers will help us determine the best approach for your physiotherapy care. Thank you!

Full Name: ____ DOB: ____________________

Health Information

Reason for attending office:

____

Location of pain:____

When did you notice it? _________________________ How often does it occur? ________________

Does it radiate? ☐ Yes ☐ No If yes where? _______________________________________

What relieves it? ____

What aggravates it? ____

When have you had this or similar conditions in the past? ___________________________________

Is condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and Goes

Other treatments tried? ____

Past Health Information

Please check if you presently have or have had any of the following conditions in the past:

☐ Blurring of vision	☐ Bronchitis	☐ Diarrhea	☐ Insomnia
☐ Stroke	☐ Asthma	☐ Stomach Ulcer	☐ Respiratory Condition
☐ Dizziness	☐ Tendonitis	☐ Heart Burn	☐ Urinary Frequency
☐ Depression	☐ Chest Pains	☐ Headaches	☐ Lower Back Pain
☐ Heart Disease	☐ Diabetes	☐ Allergies	☐ High Blood Pressure
☐ Aneurysm	☐ Hiatus Hernia	☐ Sinusitis	☐ Menstrual Problems
☐ Varicose Veins	☐ Constipation	☐ Ringing in ears	☐ Numbness or Tingling in arms or legs
☐ Cancer	☐ Arthritis	☐ Osteoporosis	

Other health problems:

____

____

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List surgical operations or hospitalizations and years they occurred:

____

____

Pregnancies:____

List of medications or vitamins you now take:

____

____

List and describe any auto accidents or other accidents/injuries:

____

____

List and describe any childhood injuries/accidents/hospitalizations/illnesses:

____

____

Anything else you feel we should know about?

____

____

Show area(s) of pain or unusual feeling.

Mark the areas on this body where you feel the described sensations.

Use appropriate symbols.

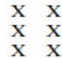
Mark areas of radiation.

Include all affected areas.

Numbness

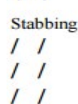
Pins & Needles

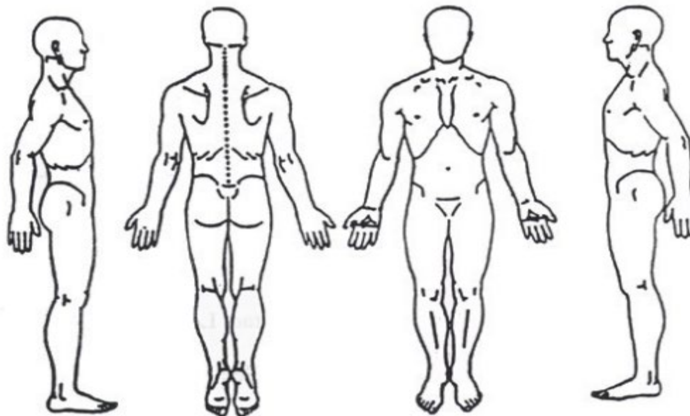
Burning



Aching

Stabbing





Please Note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow patients, we ask that you provide us with 24 hours' notice of cancellation, or a cancellation fee will be charged. Payment for all treatments, whether private or insured, is ultimately the responsibility of the patients. Late cancelation fees will be 50% of scheduled appointment time. Under one-hour notice OR no show will be charged the full appointment fee

I authorize the clinic and its associated health care professionals to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated health care professionals to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Signature: ______________________________________ **Date: _____________________________**