

Ace Physio Health History Form

An accurate health history is important to ensure that it is safe for you to receive physiotherapy treatment. Please note that all information provided below will be kept confidential unless allowed or requested by law (your permission will be required).

Name:		Date:			
Address:	Apt #:	City: Postal Code:			
Date of Birth: (day/month/year)		Occupation:			
Tel # (home)	Tel #: (cell)	Tel #: (work)			
Where/who did you hear about our clinic from:		Email:			
Medical Doctor's Name:		Referred by:			
Other Healthcare Providers (E.g. Chiropractor, Massage Therapist, Naturopath):					
<p><i>Health History- Please indicate conditions you are currently experiencing or have experienced:</i></p> <table style="width:100%; border:none;"> <tr> <td style="vertical-align: top; width:33%;"> <p>Respiratory</p> <input type="checkbox"/> Chronic cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Bronchitis <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Breathing problems <input type="checkbox"/> Sinus infections <input type="checkbox"/> Smoker <p>Cardiovascular</p> <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> CCHF <input type="checkbox"/> Heart attack <input type="checkbox"/> Heart disease <input type="checkbox"/> Phlebitis <input type="checkbox"/> Blood Clot <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> Pacemaker or similar <input type="checkbox"/> Poor circulation <input type="checkbox"/> Syncope/Fainting </td> <td style="vertical-align: top; width:33%;"> <p>Systemic:</p> <input type="checkbox"/> Loss of sensation <input type="checkbox"/> Diabetes (onset: _____) <input type="checkbox"/> Allergies (anaphylaxis/skin) <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cancer <input type="checkbox"/> Digestive complaints <input type="checkbox"/> Disorder of organ (_____) <p>Skin</p> <input type="checkbox"/> Skin conditions <input type="checkbox"/> Eczema <input type="checkbox"/> Dry skin <p>Infections</p> <input type="checkbox"/> Hepatitis <input type="checkbox"/> Skin conditions <input type="checkbox"/> TB <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Herpes <input type="checkbox"/> Contagious skin conditions <input type="checkbox"/> Lyme disease </td> <td style="vertical-align: top; width:33%;"> <p>Head/Neck</p> <input type="checkbox"/> Vision problems <input type="checkbox"/> Vision loss <input type="checkbox"/> Ear problems <input type="checkbox"/> Hearing loss <input type="checkbox"/> Headaches/Migraines <input type="checkbox"/> Vertigo/Dizziness <input type="checkbox"/> TMJ (Jaw) Dysfunction <p>Women</p> <input type="checkbox"/> Pregnant (due: _____) <input type="checkbox"/> Menstrual problems <input type="checkbox"/> Gyn. conditions : _____) <input type="checkbox"/> Oral contraceptive use <p>Other:</p> <input type="checkbox"/> Osteoarthritis (where: _____) <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Hemophilia <input type="checkbox"/> Depression <input type="checkbox"/> Other: (_____) </td> </tr> </table>			<p>Respiratory</p> <input type="checkbox"/> Chronic cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Bronchitis <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Breathing problems <input type="checkbox"/> Sinus infections <input type="checkbox"/> Smoker <p>Cardiovascular</p> <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> CCHF <input type="checkbox"/> Heart attack <input type="checkbox"/> Heart disease <input type="checkbox"/> Phlebitis <input type="checkbox"/> Blood Clot <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> Pacemaker or similar <input type="checkbox"/> Poor circulation <input type="checkbox"/> Syncope/Fainting	<p>Systemic:</p> <input type="checkbox"/> Loss of sensation <input type="checkbox"/> Diabetes (onset: _____) <input type="checkbox"/> Allergies (anaphylaxis/skin) <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cancer <input type="checkbox"/> Digestive complaints <input type="checkbox"/> Disorder of organ (_____) <p>Skin</p> <input type="checkbox"/> Skin conditions <input type="checkbox"/> Eczema <input type="checkbox"/> Dry skin <p>Infections</p> <input type="checkbox"/> Hepatitis <input type="checkbox"/> Skin conditions <input type="checkbox"/> TB <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Herpes <input type="checkbox"/> Contagious skin conditions <input type="checkbox"/> Lyme disease	<p>Head/Neck</p> <input type="checkbox"/> Vision problems <input type="checkbox"/> Vision loss <input type="checkbox"/> Ear problems <input type="checkbox"/> Hearing loss <input type="checkbox"/> Headaches/Migraines <input type="checkbox"/> Vertigo/Dizziness <input type="checkbox"/> TMJ (Jaw) Dysfunction <p>Women</p> <input type="checkbox"/> Pregnant (due: _____) <input type="checkbox"/> Menstrual problems <input type="checkbox"/> Gyn. conditions : _____) <input type="checkbox"/> Oral contraceptive use <p>Other:</p> <input type="checkbox"/> Osteoarthritis (where: _____) <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Chronic fatigue <input type="checkbox"/> Hemophilia <input type="checkbox"/> Depression <input type="checkbox"/> Other: (_____)
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Current Medications (and condition it treats):					
Previous Surgeries (Nature & Date):	Surgical Implants (E.g. Pins, plates, wires, artificial joints)				
Previous Motor Vehicle Accident:	Previous WSIB Claim:	Previous Disability Claim:			

Please sign to indicate that you have answered all of the above to the best of your knowledge. Knowingly omitting information may put your health and/or the health of your practitioner at risk, and may be deemed criminal conduct in a court of law.

Signature: _____ Date: _____
 Witness: _____ Date: _____