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):			

Health History- Please indicate conditions you are currently experiencing or have experienced:

Respiratory
- □ Chronic cough
- □ Shortness of breath
- □ Bronchitis
- □ Asthma
- □ Emphysema
- □ Breathing problems
- □ Sinus infections
- □ Smoker

Cardiovascular
- □ High blood pressure
- □ Low blood pressure
- □ CCHF
- □ Heart attack
- □ Heart disease
- □ Phlebitis
- □ Blood Clot
- □ Stroke/CVA
- □ Pacemaker or similar
- □ Poor circulation
- □ Syncope/Fainting

Systemic:
- □ Loss of sensation
- □ Diabetes (onset:_____)
- □ Allergies (anaphylaxis/skin)
- □ Epilepsy
- □ Cancer
- □ Digestive complaints
- □ Disorder of organ (_____)

Skin
- □ Skin conditions
- □ Eczema
- □ Dry skin

Infections
- □ Hepatitis
- □ Skin conditions
- □ TB
- □ HIV/AIDS
- □ Herpes
- □ Contagious skin conditions
- □ Lyme disease

Head/Neck
- □ Vision problems
- □ Vision loss
- □ Ear problems
- □ Hearing loss
- □ Headaches/Migraines
- □ Vertigo/Dizziness
- □ TMJ (Jaw) Dysfunction

Women
- □ Pregnant (due:_____)
- □ Menstrual problems
- □ Gyn. conditions :_____)
- □ Oral contraceptive use

Other:
- □ Osteoarthritis (where:_____)
- □ Rheumatoid Arthritis
- □ Fibromyalgia
- □ Chronic fatigue
- □ Hemophilia
- □ Depression
- □ Other: (_____)

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: _____