

Confidential Patient Information

I understand that the information which I give on these forms is **confidential** and will be used for no other purpose than the Physiotherapy/RMT clinic records.

*Name _____ *Date(dd/mm/yy) _____

(First)

(Last)

*Date of Birth (dd/mm/yy) _____ Age _____ Gender M F Not specified

*Address _____ *City _____ *Postal Code _____

*Home Phone # (_____) _____ Cell Phone #(_____) _____

Business Phone#(_____) _____ E-mail _____

Employer _____ Occupation _____

How did you hear about us? Friend Social Media Online Ad Other _____

***What is your primary complaint?** _____

*Is your injury (complaint) due to: (please put an **X** where applicable, if none apply, please leave blank)

a: _____ Personal Injury

b: _____ Car Accident _____

Date of Accident

c: _____ Work related injury/accident(WSIB) _____

Date Injured/ of Accident

Primary Health Care Practitioner:

Family Medical Doctor _____ Phone #(_____) _____

Address _____

Date of last appointment _____ Date of last physical _____

Please list any other Medical Doctor(s) consulted with in the last year:

Name of Dr _____ Diagnosis _____

Name of Dr _____ Diagnosis _____

***denotes required information**

Patient Name _____ DOB _____

Practitioner Name _____ Date _____

Current Health Condition(s)

Current Complaint(s) purpose of this appointment _____

Are you being treated for this complaint by any other Doctors/Therapists? Yes No

If answered 'Yes' to the above,

Who? _____ Type of Treatment _____ Results _____

When did the condition begin? _____ Has it occurred before? Yes No

Is the condition: (please put an **X** where applicable, if none apply, please leave blank)

Acute Chronic Gradual/Insidious

What Aggravates your condition? (please put an **X** where applicable, if none apply, please leave blank)

Sitting Standing Bending Lifting Lying Down Other _____ (Indicate what)

What relieves your condition? (please put an **X** where applicable, if none apply, please leave blank)

Ice Heat Bed Rest Massage Medication Other _____ (Indicate What)

Is it getting? (please put an **X** where applicable, if none apply, please leave blank)

Worse Better Comes/Goes Constant

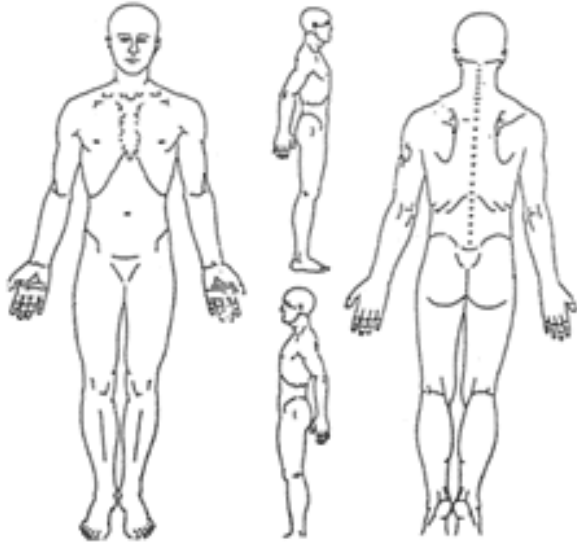
How would you describe it? (please put an **X** where applicable, if none apply, please leave blank)

Sharp Dull Ache Pins/Needles Numb Burning Constant Intermittent

Other _____ (Indicate what)

Show Area(s) of pain or unusual sensations/feeling:

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation, include all affected areas.



Numbness	Pins/Needles	Shooting	Aching	Stabbing
oooooo	pppppppp	xxxxxxxx	////////	++++++

Does this condition interfere with your ability to:

Work Enjoy family/social time

Enjoy hobbies/sports

What is your pain right now?

No Pain _____ Worst Pain Imaginable
0 1 2 3 4 5 6 7 8 9 10

Patient Name _____ DOB _____

Practitioner Name _____ Date _____

VC Therapeutics

Medications: (please list **ALL** medications you are currently taking and the condition(s) they treat

Major surgeries/injuries/medical condition(s) (please list surgery/injury/condition + date occurred/started)

Do you suffer from a **blood pressure ailment** (high or low blood pressure)? Yes No

Is it being controlled by medication? Yes No

Do you have any **allergies**? (please list)

Are you on allergy medication? Yes No

Health History

Please put an **X** beside **ANY** symptoms you are experiencing **NOW** or have experienced in the **PAST**, even if they do not seem related to your current condition /complaint.

General

- 1. ___ Fever
- 2. ___ Chills
- 3. ___ Night Sweats
- 4. ___ Loss of Sleep
- 5. ___ Fatigue
- 6. ___ Nervousness
- 7. ___ Weight Loss or Gain
- 8. ___ Bleeding Problems
- 9. ___ Anemia
- 10. ___ Diabetes
- 11. ___ Cancer
- 12. ___ Thyroid Disease/Goiter
- 13. ___ Alcoholism
- 14. ___ Drug Abuse

Eye, Ear, Nose, Throat

- 15. ___ Poor Vision
- 16. ___ Pain in Eye(s)
- 17. ___ Deafness/Difficulty Hearing
- 18. ___ Nosebleeds
- 19. ___ Nose Problems
- 20. ___ Sinus Trouble
- 21. ___ Dental Problems
- 22. ___ Hoarseness
- 23. ___ Tonsillectomy

Gastrointestinal

- 24. ___ Poor Appetite/Digestion
- 25. ___ Difficulty Swallowing
- 26. ___ Belching or Gas
- 27. ___ Frequent Nausea
- 28. ___ Vomiting
- 29. ___ Vomiting Blood
- 30. ___ Pain over Abdomen
- 31. ___ Ulcer
- 32. ___ Black or Bloody Stools
- 33. ___ Liver Problems
- 34. ___ Gall Bladder Problems
- 35. ___ Jaundice
- 36. ___ Hernia
- 37. ___ Diarrhea
- 38. ___ Constipation
- 39. ___ Hemorrhoids
- 40. ___ Appendicitis

Men Only

- 41. ___ Testicular Swelling/Pain
- 42. ___ Prostate Problems

Respiratory

- 43. ___ Difficulty Breathing
- 44. ___ Chronic Cough
- 45. ___ Spitting Phlegm
- 46. ___ Spitting Blood
- 47. ___ Wheezing/Asthma
- 48. ___ Pneumonia
- 49. ___ Tuberculosis

Cardiovascular

- 50. ___ Irregular Heartbeat
- 51. ___ Pain over Heart
- 52. ___ Previous Heart Trouble
- 53. ___ Ankle Swelling
- 54. ___ Varicose Veins
- 55. ___ Rheumatic Fever
- 56. ___ Stroke

Genitourinary

- 57. ___ Frequent Urination
- 58. ___ Painful Urination
- 59. ___ Blood in Urine
- 60. ___ Kidney Disease
- 61. ___ Urinary Infection
- 62. ___ Inability to Control Urination
- 63. ___ Difficulty Starting Urine Flow
- 64. ___ Get Up _____ Times
per Night to Urinate
- 65. ___ Breast Lump or Pain
- 66. ___ Venereal Infection
- 67. ___ Sexual Difficulties

Skin

- 68. ___ Itching
- 69. ___ Bruising Easily
- 70. ___ Change in mole(s)
- 71. ___ Skin Cancer
- 72. ___ List any other Skin
Condition(s)
-
-

Women Only

- 73. ___ Painful Periods
- 74. ___ Excessive Flow
- 75. ___ Irregular Cycles
- 76. ___ Vaginal Burning/Itching
- 77. ___ Hot Flashes
- 78. ___ Date Last Period Began _____
- 79. ___ Date of Last Pap _____

Neurologic

- 80. ___ Weakness
- 81. ___ Twitching
- 82. ___ Tremors
- 83. ___ Headaches
- 84. ___ Fainting
- 85. ___ Dizziness
- 86. ___ Convulsions
- 87. ___ Epilepsy
- 88. ___ Numbness/Tingling
- 89. ___ Arm/Leg Pain
- 90. ___ Mental/Mood Disorder

Musculoskeletal

- 91. ___ Neck Stiffness/Pain
- 92. ___ Pain Between Shoulders
- 93. ___ Low Back Pain
- 94. ___ Swollen/Painful Joints
- 95. ___ Muscle Aches/Weakness
- 96. ___ Spinal Curvature
- 97. ___ Arthritis

Habits

- 98. ___ Smoking, _____ per day/week
- 99. ___ Drinking, _____ per day/Week
- 100. ___ Recreational Drug Use
- 101. ___ Exercise, _____ times a week

Family History

Include information on brothers, sisters, parents and grandparents, **DO NOT** include yourself.

- 102. ___ Diabetes
- 103. ___ Cancer
- 104. ___ Tuberculosis
- 105. ___ Thyroid Disease/Goiter
- 106. ___ Muscle, Nerve or Bone Disease
- 107. ___ Kidney Disease
- 108. ___ High Blood Pressure
- 109. ___ Heart Disease

Patient Name _____ DOB _____

Practitioner Name _____ Date _____