VC Therapeutics

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 and to provide appropriate treatment.*

*Name_____*Current Date(dd/mm/yy)_____
(First) (Last)
*Date of Birth (dd/mm/yy)_____Age_____Gender_____

*Address_____*City_____*Postal Code_____

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

Business Phone#(_____)_____E-mail_____

How would you like to receive your appointment reminders? ☐ E-mail ☐ Text message ☐ Phone call

Employer_____Occupation_____

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

Primary Health Care Practitioner:

Family Medical Doctor_____Phone #(_____)_____

Address_____

Date of last appointment_____Date of last physical_____

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?** ☐ Yes ☐ No

If answered 'yes' ☐ high blood pressure OR ☐ low blood pressure

Is it being controlled by medication? ☐ Yes ☐ No

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

Are you on allergy medication? ☐ Yes ☐ No

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

Name of Dr_____Diagnosis_____

Name of Dr_____Diagnosis_____

***denotes required information**

Patient name:_____ Date:_____

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Current Health Condition(s)

***What is the primary reason for your visit?**_____

*Is your primary complaint/injury 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

Are you being treated for this complaint by any other Doctors/Therapists? ☐ Yes ☐ No ***If answered 'yes',***

Who?_____Type of Treatment_____Results_____

When did the condition begin?_____Has it occurred before? ☐ Yes ☐ No

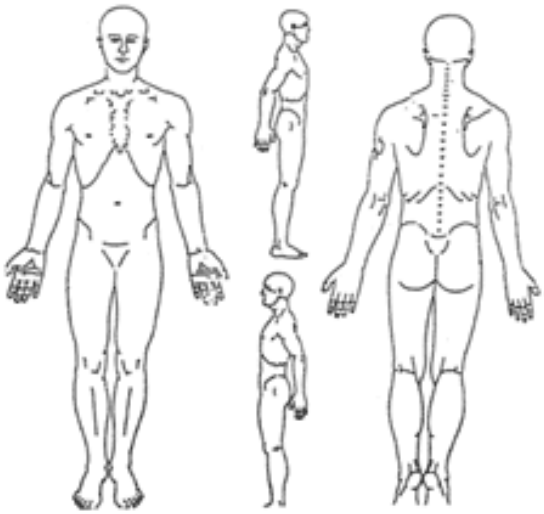
Is the condition? (*please put an* **X** *where applicable, if none apply, please leave blank)*
☐ Acute ☐ Chronic ☐ Gradual/Insidious

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 and mark all areas affected.

Numbness	Pins/Needles	Shooting	Aching	Stabbing
oooooooo	pppppppppp	xxxxxxxxx	///////////	+++++++

Does this condition interfere with your ability to:
☐ Work ☐ Enjoy family/social time
☐ Enjoy hobbies/sports

What is your pain right now?

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

***denotes required information**

Patient name:_____ Date:_____

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Health History

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

General

- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Loss of sleep
- ☐ Fatigue
- ☐ Nervousness
- ☐ Weight loss or gain
- ☐ Bleeding problems
- ☐ Anemia
- ☐ Diabetes
- ☐ Cancer:

What type/where?_____

- ☐ Thyroid Disease/Goitre
- ☐ Alcoholism
- ☐ Drug abuse

Gastrointestinal

- ☐ Poor appetite/digestion
- ☐ Difficulty swallowing
- ☐ Belching or gas
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Pain over abdomen
- ☐ Ulcer
- ☐ Black or bloody stools
- ☐ Liver Problems
- ☐ Gallbladder issues
- ☐ Jaundice
- ☐ Hernia
- ☐ Diarrhea
- ☐ Constipation
- ☐ Appendicitis
- ☐ Hemorrhoids

Respiratory

- ☐ Difficulty breathing
- ☐ Chronic cough
- ☐ Spitting phlegm
- ☐ Spitting blood
- ☐ Wheezing/Asthma
- ☐ Pneumonia
- ☐ Tuberculosis

Cardiovascular

- ☐ Irregular heartbeat
- ☐ Pain over heart
- ☐ Previous heart issues
- ☐ Ankle swelling
- ☐ Varicose Veins
- ☐ Rheumatic Fever
- ☐ Stroke

Genitourinary

- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Kidney Disease
- ☐ Urinary infection
- ☐ Inability to control urination
- ☐ Difficulty starting urine flow
- ☐ Get up_____times per night to urinate

Habits

- ☐ Smoking_____per day/week
- ☐ Drinking_____per day/week
- ☐ Recreational drug use
- ☐ Exercise_____times a week

Eye, Ear, Nose, Throat

- ☐ Poor vision
- ☐ Pain in eye(s)
- ☐ Deafness/difficulty hearing
- ☐ Nosebleeds/nose issues
- ☐ Sinus issue
- ☐ Dental Problems
- ☐ Hoarseness

Neurologic

- ☐ Weakness
- ☐ Twitching
- ☐ Tremors
- ☐ Headaches
- ☐ Fainting
- ☐ Dizziness
- ☐ Convulsions
- ☐ Epilepsy
- ☐ Numbness/tingling
- ☐ Arm/leg pain
- ☐ Mental/mood disorder

Musculoskeletal

- ☐ Neck stiffness/pain
- ☐ Pain between shoulders
- ☐ Low back pain
- ☐ Swollen/painful joints
- ☐ Muscle aches/weakness
- ☐ Spinal curvature
- ☐ Arthritis

Skin

- ☐ Itching
- ☐ Bruising easily
- ☐ Change in mole(s)
- ☐ List any other skin condition(s)

-
-
-

Family History

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

- ☐ Diabetes
- ☐ Cancer
- ☐ Tuberculosis
- ☐ Thyroid disease/Goitre
- ☐ Kidney Disease
- ☐ High blood pressure
- ☐ Heart Disease
- ☐ Muscle, nerve or bone disease

Patient name:_____ Date:_____