KAWARTHA THERAPEUTIC CENTRE

YOUR PHYSIO TEAM:

AJ VARGHESE – Physiotherapist
DALE ANDREW –Strength Coach, Exercise Rehab
JESSICA LYALL – Technician, Therapeutic Assistant
DR. MICHAEL CARNEY - Chiropractor

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CONFIDENTIAL PATIENT INFORMATION FORM

Please take a few moments to complete this form as accurately as possible. Your answers will help us determine if we are able help you (and therefore, if we can accept your case). If we believe that your condition will respond more favourably with another health care provider, we will be happy to refer you. If you need help with the form, please do not hesitate to ask our receptionists.

Name: _____ Date: _____
Address: _____City: _____Postal Code:_____
Home Tel: ( ) _____ Cell Tel: ( ) _____Work Tel: _____
Date of Birth (D/M/Y): _____ Age: _____ Gender: ☐ male ☐ female
E-mail address: _____ (100 % confidential - for appointment reminders/clinic newsletter)
Family Status: ☐ single ☐ married ☐ widowed ☐ divorced # of children _____ Ages: _____
Occupation: _____Employer: _____
Extended Health Care Company: _____
Medical Doctor's name: _____
Approximate date of last medical appointment: _____Reason for visit: _____
How did you hear about our office? ☐ A friend: if so, who?_____
☐ Medical Doctor ☐ Sign ☐ Ad ☐ Website ☐ Other: _____
Have you ever been to a physiotherapist before? ☐ No ☐ Yes, if Yes, reason for visit:_____

DESCRIPTION OF CURRENT INJURY/PAIN

Please describe your major complaint(s) including area(s) of the body affected, and your best reasoning as to what caused it: _____
_____
_____
_____
_____
When (what date or how long ago) did you first notice the problem? _____
Please rate the severity of your complaint by checking one box on the below scale.

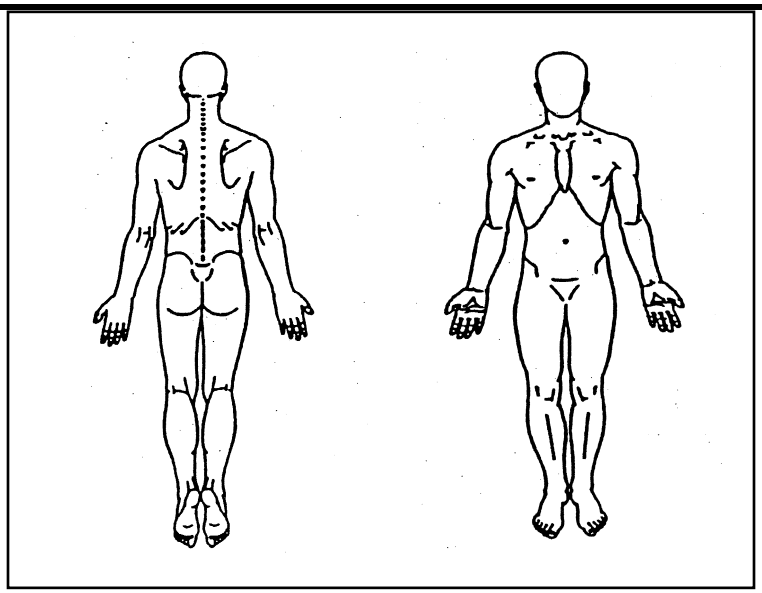
No Problem	1	2	3	4	5	6	7	8	9	10	Severe Problem

(At best/at worst) _____
Is the complaint constant, frequent or infrequent?_____
When do you notice your complaint the most? _____
What aggravates your complaint? ☐ Sitting ☐Standing ☐ Bending ☐ Lifting
☐ Walking ☐ Bed Rest ☐ Weather Changes ☐ Other _____
What relieves your complaint? ☐ Ice ☐ Heat ☐ Massage ☐ Stretches ☐ Bed Rest ☐ Walking
☐ Medications ☐ Other_____
Is it getting: ☐ Worse ☐ Better ☐ Constant ☐ Comes and Goes

Characteristics of the pain:

Using the key below, mark the areas of your body where you feel the described sensations. Use the appropriate symbols. Circle the area if you are unable to describe the sensation. Also mark areas of shooting or radiating symptoms. Include all affected areas:

XXX = Sharp Pain
TTT = Tense/Tight
BBB = Burning
AAA = Ache
+++ = Pins& Needles
///= Numbness
->->-> = Radiates
OOO = Other (describe)



What treatments have you had for this problem? □ Chiropractic □ Physical Therapy □ Massage □ Medical Treatment □ Acupuncture □ Other Procedures _____

Have you ever had this or a similar problem before? _____

Do you have any other (secondary) complaints? **Please Describe:** _____

_____

_____

Have you had any diagnostic studies? □ X-rays □ CT scans □ MRI scans □Lab work □ EMG's □ Other_____

How does this problem affect your life with respect to:

Your ability to work?_____

Your ability to enjoy family/social time/activities/sports? _____

GENERAL HEALTH

Compared to 5 years ago, would you say your overall health is: □ better □ staying the same □ worse

Overall Stress Levels: □ high □ med-high □ medium □ med-low □ low

Medications you currently take: □ Painkillers □ Muscle Relaxants □ Anti-inflammatory □ Heart Meds □ Insulin □ For Indigestion □For Depression □ For Anxiety □ For Asthma □ Blood Pressure □ HRT □ Other _____

Natural supplements you currently take: □ Multivitamin □ Vitamin C □ B-complex vitamins □ Calcium □ Omega3/6/9 □ Prenatal vitamin □ Folic Acid □ Glucosamine □ Homeopathic □ Naturopathic remedies □ Other _____

What is your personal satisfaction with your diet? □ Highly satisfied □ Satisfied □ Dissatisfied □ Highly Dissatisfied

Do you have a regular exercise program? □ No □Yes What type, and how often? _____

Do you wear orthotics? □ Yes □ No If yes – approximately how old are they? _____

Do you use tobacco? □ No □ Yes - Amount: _____ □ In the past - what year did you quit? _____

Do you use alcohol? □No □ Yes – Occasionally □ Yes – Regularly

Do you suffer from any other health conditions? □ No □ Yes (please list) _____

_____

PAST HEALTH HISTORY:

Please describe any hospitalizations or surgical operations and state the approximate dates: _____

_____

Please describe any previous traumas (accidents, sports injuries, work injuries, etc) and approximate dates: _____

_____

_____

The follow is a list of conditions, which may seem unrelated to your current complaint. However, we would like to assess your full health picture, and some of these conditions can also be affected by your overall courses of care. Please check the appropriate box for any of the following symptoms which you have now or have experienced previously. **C= currently** **P= previously**

C P
- ☐ ☐ Diabetes
- ☐ ☐ Loss of consciousness
- ☐ ☐ Blackouts/fainting
- ☐ ☐ Convulsions
- ☐ ☐ Dizziness
- ☐ ☐ Headaches
- ☐ ☐ Loss of sleep
- ☐ ☐ Fever
- ☐ ☐ Sweats
- ☐ ☐ Clumsiness
- ☐ ☐ Loss of balance
- ☐ ☐ Numbness in arm/hand
- ☐ ☐ Numbness in leg/foot
- ☐ ☐ Depression
- ☐ ☐ Fatigue
- ☐ ☐ Anxiety
- ☐ ☐ Forgetfulness
- ☐ ☐ Allergies
- ☐ ☐ Recent weight gain
- ☐ ☐ Recent weight loss

SKIN
C P
- ☐ ☐ Itching
- ☐ ☐ Skin rash
- ☐ ☐ Bruises easily
- ☐ ☐ Psoriasis
- ☐ ☐ Varicose veins

MUSCLE & JOINT
C P
- ☐ ☐ Osteoporosis
- ☐ ☐Arthritis
- ☐ ☐ Bursitis
- ☐ ☐ Swollen joints
- ☐ ☐ Foot trouble
- ☐ ☐ Hernia
- ☐ ☐ Low back pain
- ☐ ☐ Neck pain
- ☐ ☐ Neck stiffness
- ☐ ☐ Pain in the joints
- ☐ ☐ Weakness
- ☐ ☐ Jaw pain/TMJ

CARDIOVASCULAR
C P
- ☐ ☐ Aneurysm
- ☐ ☐ Angina
- ☐ ☐ Bleeding disorder
- ☐ ☐ High blood pressure
- ☐ ☐ Pain over the heart
- ☐ ☐ Stroke
- ☐ ☐ Heart attack
- ☐ ☐ Ankle swelling

EYES, EARS, NOSE& THROAT
C P
- ☐ ☐ Wear glasses/contacts
- ☐ ☐ Blurred/double vision
- ☐ ☐ Eye pain
- ☐ ☐ Deafness
- ☐ ☐ Ear aches
- ☐ ☐ Ringing or buzzing in ears
- ☐ ☐ Sinus infections
- ☐ ☐ Enlarged glands
- ☐ ☐ Enlarged thyroid
- ☐ ☐ Difficulty swallowing

GENITO-URINARY
C P
- ☐ ☐ Bed wetting
- ☐ ☐ Painful urination
- ☐ ☐ Blood in urine
- ☐ ☐ Frequent urination
- ☐ ☐ Loss control urine
- ☐ ☐ Kidney infection
- ☐ ☐ Prostate trouble

LUNG&BREATHING
C P
- ☐ ☐ Asthma
- ☐ ☐ Difficulty breathing
- ☐ ☐ Chest pain
- ☐ ☐ Chronic cough
- ☐ ☐ Wheezing
- ☐ ☐ Spitting blood

GASTROINTESTINAL
C P
- ☐ ☐ Poor appetite
- ☐ ☐ Loss of weight
- ☐ ☐ Indigestion
- ☐ ☐ Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Vomiting blood
- ☐ ☐ Pain over stomach
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Ulcer
- ☐ ☐ Jaundice

WOMEN ONLY
C P
- ☐ ☐ Painful menstruation
- ☐ ☐ PMS
- ☐ Pregnant
  Due date_____

# of pregnancies _____
# of children _____
Menopausal? Y / N

FAMILY HEALTH HISTORY

Is there any current or past history of medical conditions, diseases, or illnesses in your family? What medical problems do your parents or siblings have? Please list relationship and problem: (ex: Peter – Father - diabetes)

_____

_____

PLEASE CHECK THE PHRASE THAT MOST REPRESENTS YOUR REASONS FOR CARE:

☐ Symptom relief - i.e. get rid of the pain!

☐ Corrective/Functional Care - i.e. get rid of the pain, but also address any underlying factors that may contribute to my symptoms, or may cause future problems. ex. weak muscles, chronic spinal dysfunction, poor posture, chronic tightness, etc.

☐ Performance/Wellness Care - i.e. I acknowledge that there are many causes of daily repetitive physical stress to my body - keep me performing my best – at home, at work, and/or at play.

CORRESPONDANCE WITH YOUR PHYSICIAN:

Would you like me to send your physician or other health care provider a report detailing my assessment findings and plan of management? ☐ Yes ☐ No ☐ At your discretion