



## CONFIDENTIAL CASE HISTORY

### PERSONAL INFORMATION:

Date: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Prov. \_\_\_\_\_ Postal \_\_\_\_\_

Home Ph. \_\_\_\_\_ Cell \_\_\_\_\_

E-Mail Address \_\_\_\_\_ I consent to receive correspondence via email  initial

Birth date; M: \_\_\_\_ D: \_\_\_\_ Y: \_\_\_\_ Age \_\_\_\_ Marital Status:  M  S  W  D

Occupation \_\_\_\_\_

What occupies your spare time? \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Type of Coverage:  MSP  WCB  ICBC  other: \_\_\_\_\_

B.C. Care Card Number: \_\_\_\_\_

### HEALTH INFORMATION:

Medical Doctor's Name: \_\_\_\_\_

Have you had previous physiotherapy?  yes  no When? \_\_\_\_\_ Why? \_\_\_\_\_

What is your major complaint? \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_ Have you had it before?  yes  no

What aggravates your condition \_\_\_\_\_

Is it getting:  Better  Worse  Constant  Comes and goes

Is this condition interfering with your:  Work  Sleep  Daily routine  Other \_\_\_\_\_

How long has it been since you really felt good? \_\_\_\_\_

Others who treated this condition: \_\_\_\_\_

List surgical conditions and years: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Drugs you now take: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## HEALTH HISTORY:

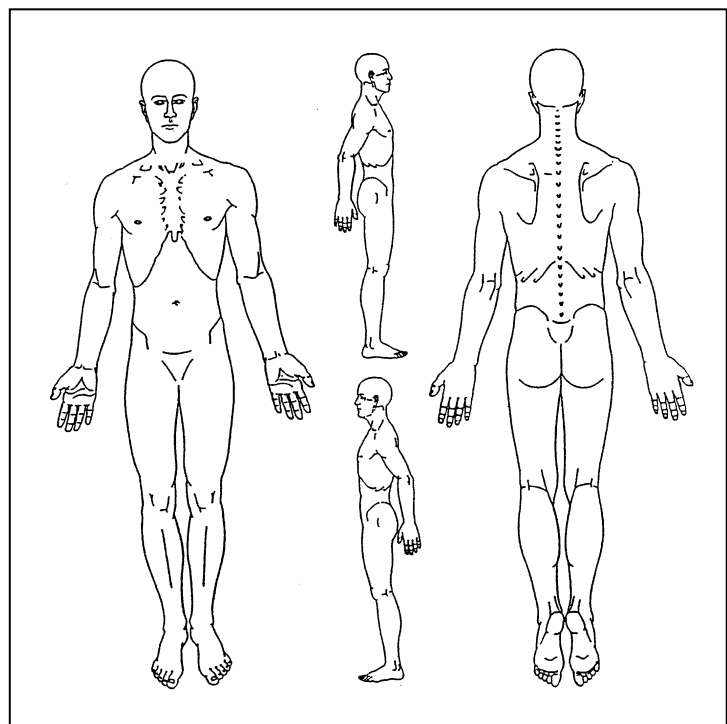
To provide us with a more complete clinical picture, please answer the following questions, even if you do not think they are related to your health problem.

Pain is often referred from other areas or it may be related to a more serious underlying pathology.

Have you ever suffered from:

Please mark the main areas of pain on the diagram below:

- |                                   |  |
|-----------------------------------|--|
| 1. Heart attack                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Heart disease                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Chest pain / angina            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. High blood pressure            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. On blood thinners              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Pacemaker                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Dizziness                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Stroke                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Seizures                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Diabetes                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. TB                            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Asthma/breathing difficulties | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Cancer                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Osteoarthritis                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Rheumatoid arthritis          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Osteoporosis                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Joint replacement             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Recent fractures              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. Recent surgery                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. Metal/cement implants         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Bowel/bladder abnormalities   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 22. Allergies                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |



What type(s)? \_\_\_\_\_

23. Other \_\_\_\_\_