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:

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

23. Other _____

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