MEDICAL HEALTH HISTORY FORM

Please complete this questionnaire. All information will be kept strictly confidential.

PERSONAL INFORMATION

Name: _____

Address: _____City: _____ Postal Code:_____

Telephone: (Home) _____ (Mobile) _____

Occupation:_____ EMAIL:_____

Date of Birth (yyyy:mm:dd): _____ Age:_____

Marital Status:_____ Referred By:_____

Physician's Name / Address / Tel. No._____

_____

☐ I consent to receiving emails and texts from EQ Physio (Re: appointment reminders, clinic updates, promotions) – I understand that I can withdraw consent at any time.

☐ I consent to my therapist communicating to my physician any updates on my progress

CURRENT HISTORY

What are your most important priorities for this visit? (please provide two goals you want to achieve during the initial consult)

Have you been treated for this before? **Y** **N** If yes, by whom? _____

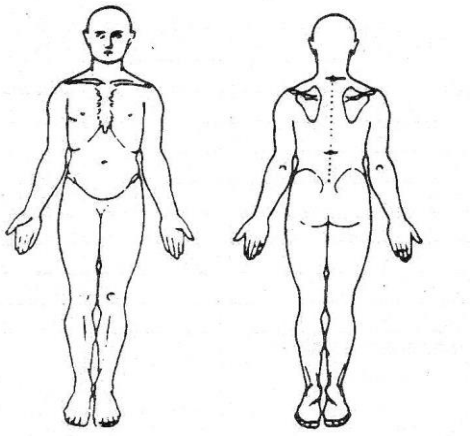
Please note anything you did not like about your previous therapy: _____

Imaging Results: (X-Rays, MRI, CT, Bone Scan, Ultrasound)

_____

INDICATE CURRENT SYMPTOMS ON THE FIGURES

P = areas of pain
X = areas of joint stiffness
S = areas of numbness & tingling
# = areas of scars, bruises & open wounds



Dominant Hand (circle one): **R** **L**

Any wires, pins, artificial limbs, special equipment? **Y** **N**

Exercise / Activities (when injury free) list activities, frequency, duration as well as goals:

_____

_____

How many days per week do you do cardio for at least 30 minutes? _____

Do you do any strength training? **Y** **N**

Do you think exercise is causing you to flare up? **Y** **N**

(please turn over)

EQ physio
ACHIEVING BALANCE + EQUILIBRIUM

MEDICATIONS / SUPPLIMENTS

List all prescription and non-prescription medications you are currently taking:

_____

Has your medication dosage changed recently? **Y N** Are you on Blood Thinners? **Y N**

Have you been on prednisone in the last year? **Y N**

Have you been treated with chemotherapy? **Y N** If yes, when? _____

Are you taking any vitamin / mineral / herbal supplements? **Y N** If yes, what? _____

LIFESTYLE HABITS

Do you have any food sensitivities or food allergies? **Y N**
If yes, what? _____

What is your primary source of daily protein intake? _____

Do you drink coffee? **Y N** If yes, how many cups / day?_____

Do you drink tea? **Y N** If yes, how many cups / day?_____

Do you drink milk? **Y N** If yes, how many cups / day?_____

Do you drink water? **Y N** If yes, how many cups / day?_____

How much alcohol do you drink / week? _____

Do you smoke? **Y N** If yes, how much? _____ For how many years?_____

How many hours of **actual** sleep do you get each night? **(circle one) less than 7 / 7-9 / 10-12**

Do you have trouble falling asleep? **Y N** If yes, why? _____

MEDICAL HISTORY – Do you have, or have you had, any of the following? (CIRCLE all that apply)

Lung Chronic Cough Asthma Shortness of Breath Bronchitis Emphysema Difficulty Breathing w/ Exercise **Blood Vessels** Varicose Veins Blood Clots (DVT) Leg Swelling Arteriosclerosis	**Heart** Chest, Arm or Jaw Pain with Exercise High Blood Pressure Low Blood Pressure Poor Circulation Heart Attack Angina Pacemaker Enlarged Heart Fainting Coronary Artery Disease Stroke Anemia	**Gastrointestinal** Difficult Digestion Irritable Bowel Crohn's or Colitis Disease GERD (Acid Reflux) Gall Bladder Stones Ulcer Constipation (0-1 bowel movements daily) Diarrhea Bloating Bloody Stool Liver Problems (Hepatitis or Jaundice)
Kidney Kidney Failure Kidney Stones Pain with Urination Bladder Infection	**Hormonal** Thyroid Condition (Hypo / Hyper) Adrenal Condition Diabetes	**Skin** Cellulitis Psoriasis Hypersensitivity / Allergies Bruise Easily

Reproductive Organs **Females:** Menopause Pregnant Difficult Labour or Delivery Planning Children Infertility Ovarian Cysts Endometriosis Pelvic Pain **Males:** Prostate Infection or Cancer Hernia Testicular Pain / Cancer	**Musculoskeletal** Osteoporosis Osteoarthritis Rheumatoid Arthritis Ankylosing Spondylitis Gout Degenerative Disc Disease Low Back Pain Neck Pain Middle Back Pain Shoulder Pain Fractures (broken bones) Leg Pain Knee Pain Foot and Ankle Pain	**Neurologic** Seizures Multiple Sclerosis Concussion Head Injury Headaches Vision Problems Hearing Problems Earaches Dizziness / Vertigo **Mental** Depression General Anxiety Memory Loss Panic Attacks

Surgeries (list all surgeries, including C sections and the year of procedure):

_____

Other: e.g. Cancer / Tuberculosis / HIV Infection

_____

What are your major stressors? _____

Family History: _____

HOW DID YOU HEAR ABOUT THE CLINIC? (circle one)

DOCTOR GOOGLE CURRENT CLIENT (name)_____

SIGN OUTSIDE ARTICLE/PUBLICATION OTHER_____

INFORMED CONSENT

It is my choice to receive therapy and I understand that the treatment that is being provided for the well being of my body and mind. I agree to communicate with my therapist if my well being is being compromised.
I understand that the therapist will outline the treatment and will commence once consent has been obtained. I understand that I may stop treatment any time I choose.
I acknowledge that therapy is not a substitute for medical examination or diagnosis and it is recommended that I see a physician for that service.

SIGNATURE_____**DATE**_____

CANCELLATION POLICY:
Please inform clinic 24 hours to appointment. Repeat no shows will be charged $30