Medical History **Name (Print):** _____

Your Physiotherapist will take a medical history as part of your assessment. To help this process, please let us know if you have had any of the following problems / conditions. Do your best to answer. ✓

□ Unexplained weight loss or gain	□ Headaches □ Migraines	□ Problems sleeping
□ Fever / chills □ Weakness	□ Itchy Eye □ Red eye	□ Tired / fatigued very often
□ Numbness where you sit	□ Ringing or buzzing in ears	□ Dizziness □ Light-headedness
□ Changes in appetite □ Night pain	□ Nasal congestion □ Post nasal drip	□ Reduced concentration
□ Recent or recurrent infection	□ Itchy nose □ Runny nose	□ Reduced attention
□ Bladder or bowel control problems	□ Dry mouth □ Chronic cough	□ Memory problems
□ Swallowing difficulty	□ Snoring □ Sleep apnea	□ Spaciness / fogginess in your head
□ Speech problems □ Fainting spells	□ Shortness of breath	□ Concussion
□ Recent abdominal pain	□ Asthma □ Allergy	□ Clumsiness / poor coordination
□ Double / blurred / or changes in vision	□ Rash □ Dry Skin	□ Problems with balance / walking
□ Involuntary movements	□ Changes in your finger nails	□ ADHD □ ADD □ Dyslexia
□ Family history of MS or cancer	□ Restricted diet /food sensitivity	□ Wear Bifocals / Trifocals
□ Sustained morning stiffness	□ Swelling in hands or feet	□ Confuse left and right easily
□ Long term steroid use	□ Angina or Chest pain	□ Ambidextrous (use left & right)
□ Felt a heartbeat in your abdomen	□ Blood pressure (high / low)	□ Born low birth weight / premature
□ Blood clots □ Blood disorders	□ Palpitations □ Leg cramps	□ Born with birth complications
□ Circulation problems	□ Heart attack □ Heart conditions	□ Born by C-section
□ Anticoagulant therapy	□ Pace maker □ Stroke	□ Walked quickly or delayed
□ Hearing problems	□ Heartburn □ Acid reflex	□ Serious childhood illness
□ HIV □ Hepatitis	□ Constipation □ Bloated	□ Depression □ Anxiety □ Stress
□ Metal implants □ Cancer (any type)	□ Irritable bowel syndrome	□ Alcohol or Drug addiction
□ Kidney Disease/Stones	□ Ulcer □ Stomach Problems	□ Obsessive compulsion disorder
□ Osteoarthritis (arthritis of the joints)	□ Restless legs □ Night pain	□ Fear of crowds / claustrophobia
□ Osteoporosis □ Excessive flexibility	□ Numbness / Pins & Needles	□ Hormonal problems
□ Autoimmune disorder	□ Easy bruising □ Night Sweats	□ Menopause year: _____
□ Rheumatoid arthritis	□ Heat or cold intolerance	□ Changes in menstruation patterns
□ Ankylosing spondylitis	□ Excessive thirst or sweating	□ Fibromyalgia
□ Current pregnancy (or suspected)	□ Blotchiness or redness in skin	□ Diabetes

Have you ever experienced pain in the area before? □ Yes □ No

Have you ever experienced any trauma to your spine (e.g. car accident, falls)? _____

Do you take regular medication? If so, what are they and what conditions are they for? _____

_____

Please list any previous surgeries you have had and when: _____

_____

Please list any previous injuries you have had (e.g. sprains, broken bones)_____

_____

Do you have any other medical conditions that may affect your treatment? Please list: _____

_____

What types of medical diagnostic testing have you had done to date (e.g. X-Ray, MRI, CT scan, bone scan, blood work)? _____

What medical other health care professionals have you seen for your complaint to date? (GP, massage therapist, chiropractic, physiotherapist) _____

Do you feel that you understand your diagnosis? □ Yes □ No _____

Signature: _____ Date: _____