MOMENTUM HEALING ARTS CENTRE

Physiotherapy Patient Information Form

Name: _____

Date of Birth: _____

Address: _____

Email: _____ Phone Number: _____

Contact person in case of Emergency: _____ Phone: _____

Who is your family doctor? _____

Chief Complaint/Injury: _____

When did this problem start? _____

Have you ever had this problem before? _____

Have you had any previous physiotherapy for this problem? _____

Did your doctor send you for any tests (X-rays, CT scan, MRI etc.)?

Mark the best number that corresponds to your pain:

At Best: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

0 1 2 3 4 5 6 7 8 9 10

No pain Moderate Worst

At Worse: |_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|

0 1 2 3 4 5 6 7 8 9 10

No pain Moderate Worst

What makes your condition better?

☐ Bending ☐ Lying ☐ Standing ☐ Walking ☐ Sitting ☐ Better as day progresses

☐ Medications ☐ Change in Positions ☐ Ice ☐ Heat ☐ Better in am ☐ Better in pm

What makes your condition worse?

☐ Bending ☐ Sitting ☐ Walking ☐ Standing ☐Stairs

☐ Lying ☐ Worse as day progresses ☐ Worse in am ☐ Worse in pm

Please list the medications that you are taking: _____

Please list any allergies you might have: _____

Do you have an electrical implant such as pacemaker or spinal stimulator? ☐ Yes ☐ No

If yes, please list location: _____

Please list previous surgeries: _____

Has your doctor ever prescribed nitro medications for you? ☐ Yes ☐ No

If yes, when was the last time you used nitro? _____

Are you, or is there a chance that you might be pregnant? ☐ Yes ☐ No

Has a doctor ever told you that you have the following condition?

☐High Blood Pressure ☐Angina or Heart Pain ☐Heart Attack ☐Stroke ☐Arthritis

☐Kidney Disease ☐Cancer ☐Tuberculosis ☐Blood Disease ☐Diabetes ☐Hepatitis

☐VRE ☐MRSA

How tall are you? _____ How much do you weigh? _____

Is this problem preventing you from working? ☐ Yes ☐ No

What are your goals from physiotherapy? _____

_____

_____ _____ _____

(Name of person completing this form) (Signature of person completing this form) (Date)