Physiotherapy III LTD.
www.physio3.com

Owen Sound Clinic
318383 Grey Road 1
Owen Sound, ON N4K 5N4
T: 519-372-1920 • F: 519-372-1888

Port Elgin Clinic
553 Bricker Street
Port Elgin, ON N0H 2C4
T: 519-389-3393 • F: 519-389-5888

Physiotherapy Health History Information Sheet

General Patient Information:

Date:_____ Name:_____

Address:_____ City:_____

Postal Code:_____ Phone Number: _____

Cell Number:_____ Date of Birth: _____

Email:_____ Date of Injury (can be approximate if unknown):_____

Health Card #:_____ Health Card Expiry Date:_____

Emergency Contact:

Name:_____ **Phone Number**:_____

Family Physician:_____ Specialist:_____

Where did you hear about us? ☐ Newspaper ☐Doctor ☐ Friends/relatives ☐ Seminars ☐Flyers

☐ Other: _____

Are you currently seeing any of the following: ☐ Chiropractor ☐ Massage Therapist

Motor Vehicle Accident Information:

MVC Insurance Co.:_____ Claim #:_____ Policy #:_____

Agent:_____ Branch Location/Address: _____

Adjuster Phone #: _____ Adjuster Fax #:_____

Extended Health Benefits (ie. Work Benefits): We offer direct billing for most but not all carriers

Carrier:_____ Employer:_____ Policyholder Name:_____

Relation to Policyholder:_____ Policyholder DOB:_____ Policyholder Gender:_____

Policy #:_____ ID #:_____ Claim #:_____

How Can We Help?

Physiotherapy can help with pain, movement, strength, balance, dizziness, concussion from a variety of causes. From your perspective, what is the main reason you are visiting us today? (ex. Shoulder Pain)

_____

List 1-3 activities that are important to get back to once feeling better.

1._____

2._____

3._____

Medical History:

Have you ever been told you have:

	yes	no
Cancer	☐	☐
Diabetes	☐	☐
Hypoglycemia	☐	☐
Hypertension or high blood pressure	☐	☐
Heart disease	☐	☐
Angina or chest pain	☐	☐
Shortness of breath	☐	☐
Stroke	☐	☐
Kidney disease/stones	☐	☐
Urinary tract infection	☐	☐
Allergies	☐	☐
Asthma, hay fever	☐	☐
Cirrhosis/liver disease	☐	☐
Rheumatic/scarlet fever	☐	☐
Polio	☐	☐
Pneumonia	☐	☐
Emphysema	☐	☐
Migraine headaches	☐	☐
Anemia	☐	☐
Ulcers/stomach problems/GERD	☐	☐
Arthritis/gout	☐	☐
Blood related condition	☐	☐
(i.e. Hemophilia, Hepatitis, Guillan-Barre syndrome)	☐	☐
Epilepsy	☐	☐
Thyroid problems	☐	☐
Multiple sclerosis	☐	☐
Tuberculosis	☐	☐
Fibromyalgia/Myofascial Pain Syndrome	☐	☐
Is there a chance you may be pregnant?	☐	☐

Osteoporosis	□	□
Latex Intolerance	□	□
Vertigo	□	□
Concussions	□	□
Anxiety or Depression	□	□

Recent surgeries: (please list) _____

Work Environment:

1) Occupation:
2) Does your job involve:
   - □ prolonged sitting (e.g. desk, computer, driving)
   - □ prolonged standing (e.g. equipment operator, sales clerk
   - □ prolonged walking (e.g. mill worker, delivery service)
   - □ use of large or small equipment (e.g. telephone, fork lift, keyboard, drill press, cash register)
   - □ lifting, bending, twisting, climbing, turning
   - □ exposure to chemicals, pesticides, toxins, or gases

other: please describe

3) Do you use any special supports:

□ back cushion, neck cushion
□ back brace, corset
□ other kind of brace or support for any body part

4) History of falls:

□ I have had no falls
□ I have just started to lose my balance/fall
□ I fall occasionally
□ Certain factors make me cautious (e.g. curbs, ice, stairs, getting in and out of the tub)

Medical History:

1) Are you taking any prescription or over the counter medications? If yes, please list and what they are for:

_____

2) Have you noticed any lumps or thickening of skin or muscle anywhere on your body?

☐ Yes ☐ No

3) Do you have any sores that have not healed or any changes in size, shape or colour of a wart or mole?

☐ Yes ☐ No

4) Have you had any unexplained weight gain or loss in the last month?

☐ Yes ☐ No

5) Are you on any special diet prescribed by a physician?

☐ Yes ☐ No

6) Do you have a pacemaker, transplanted organ or metal implants/joints replacements?

☐ Yes ☐ No

Payment for services is due on receipt unless our office has confirmation of other funding sources.

Please let the clinic know at least 24 hours before your appointment if you are unable to attend, or a late cancellation fee of the visit amount will be applied to your account

I hereby consent to physiotherapy treatment as explained to me.

We may obtain your health information from other healthcare providers to continue to care for you. We may also on occasion share this information with other healthcare providers for the purposes of continuity of care. This includes healthcare providers at other organizations who are able view your information through shared electronic systems/databases

Print Name	Signature	Date
_____	_____	_____
Witness Name	Signature or Witness	Date
_____	_____	_____