lakeside
Physiotherapy & Massage

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Physiotherapy Patient Information Form

1. Please indicate any of the following conditions **you** have:

	YES	NO		YES	NO
Arthritis	☐	☐	Hernia	☐	☐
Diabetes	☐	☐	Depression	☐	☐
Thyroid Condition	☐	☐	Osteoporosis	☐	☐
Dizziness/Fainting	☐	☐	Smoking History	☐	☐
Low/High Blood Pressure	☐	☐	Raynauds	☐	☐
Heart Condition	☐	☐	Sleeping Problems	☐	☐
Chest Pain	☐	☐	Cough	☐	☐
Pacemaker	☐	☐	Vision Difficulties	☐	☐
History of Cancer	☐	☐	Swallowing Difficulties	☐	☐
Allergies to tape/latex	☐	☐	Slurred Speech	☐	☐
Any Allergies	☐	☐	Memory Problems	☐	☐
Epilepsy/Seizures	☐	☐	Balance Problems	☐	☐
Shortness of Breath	☐	☐	Recent Falls/Blackouts	☐	☐
Asthma	☐	☐	Unexplained Weight Loss	☐	☐
Bronchitis	☐	☐	Groin Numbness/Tingling	☐	☐
Other Respiratory Condition	☐	☐	Bowel & Bladder Difficulties	☐	☐
Hearing Impairment	☐	☐	Headaches	☐	☐
Pregnancy	☐	☐	Blood Diseases	☐	☐
Metal Implants (Incl. IUD)	☐	☐	Other: _____		

SURGERIES: (please list) _____
PREVIOUS INJURIES: _____
Dates: _____
INJECTIONS: (please list)
_____
Dates: _____

2. a) Do you sleep through the night? ☐ YES ☐ NO
   b) Do you wake but feel unrested? ☐ YES ☐ NO
   c) What position do you sleep in? ☐ Lying on back ☐ lying on stomach ☐ lying on side
3. Is there anything else we should know about your health? _____
_____
4. Do you have a return appointment with the doctor who referred you? ☐ YES ☐ NO
If yes, when? _____
5. What do you expect/hope to achieve from therapy? _____
_____

Please Turn Over

Physiotherapy Patient Information Form (Cont'd)

6. Rank the following changes in order of their important to you:
(1= most important, 8= least important)

__ Decrease Pain
__ Increase Movement
__ Increase Strength
__ Increase ability to manipulate objects
__ Increase Endurance
__ Increase Work Capacity
__ Return to Work
__ Other:
_____

7. Are you presently receiving or have you ever received any of the following treatment for your current problem?

☐ Chiropractic ☐ Massage ☐ Occupational Therapy ☐ Naturopathic
☐ Reflexology ☐ Acupuncture ☐ Physiotherapy ☐Podiatry

8. Please list any medications you are currently taking

MEDICATION	DOSE	HOW OFTEN

9. Have you had any of the following tests for the condition for which you are presently referred?

TEST	YES	NO	WHEN	LOCATION OF TEST	RESULTS
X-rays					
CT Scan					
EMG/Nerve Conduction					
MRI					
Bone Density Study					
Ultrasound					
Other (specify) _____					

Consent to Treatment:

_____ _____
SIGNATURE (Patient or Parent/Guardian) DATE