

CONFIDENTIAL PATIENT CASE HISTORY

As Physiotherapy practice providing comprehensive care, we focus on your ability to be healthy. Our goals are firstly, to address the issues that brought you to this practice. Secondly, to treat the cause of your condition (not just treat the symptoms or place a temporary patch over your condition), and thirdly, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of your health.

What is your major problem? _____

How long have you had this problem? _____

Have you had this or a similar problem in the past? _____

If you are experiencing pain, please tick the words that best describe your pain:

- | | | | |
|---|---|-----------------------------------|--|
| <input type="checkbox"/> Constant | <input type="checkbox"/> Intensity varies | <input type="checkbox"/> Sharp | <input type="checkbox"/> Travels /Radiates |
| <input type="checkbox"/> Comes and goes | <input type="checkbox"/> Intensity doesn't vary | <input type="checkbox"/> Shooting | <input type="checkbox"/> Achy |

Please rate your pain (No pain) 0-----10 (Severe pain)

Do you get?

- | | | | |
|---|-----------------------------------|-----------------------------------|-----------------------------------|
| <input type="checkbox"/> Pins and needles | <input type="checkbox"/> Tingling | <input type="checkbox"/> Numbness | <input type="checkbox"/> Weakness |
|---|-----------------------------------|-----------------------------------|-----------------------------------|

Since the problem started is it:

- | | | |
|---|---|--|
| <input type="checkbox"/> About the same | <input type="checkbox"/> Getting better | <input type="checkbox"/> Getting worse |
|---|---|--|

What makes it worse?

- | | | | |
|----------------------------------|---|----------------------------------|--------------------------------|
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing up from a chair | <input type="checkbox"/> Walking | <input type="checkbox"/> Other |
|----------------------------------|---|----------------------------------|--------------------------------|

Interferes with:

- | | | | |
|-------------------------------|--------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> Work | <input type="checkbox"/> Sleep | <input type="checkbox"/> Hobbies | <input type="checkbox"/> Leisure |
|-------------------------------|--------------------------------|----------------------------------|----------------------------------|

What type of work do you do? _____

What sports or hobbies do you participate in? _____

Other health professionals seen for this problem (please list):

Medical Doctor _____ Chiropractor _____

Specialist Doctor/Surgeon _____ Other _____

List any medications you are taking _____

Have you ever taken oral cortisone or prednisone (including asthma medications such as pulmicort, symbicort, flixotide & seretide)? Y/N

Are you pregnant or trying to fall pregnant? Y/N

Do you have or have you ever had any of the following: (please tick)

- | | | |
|---|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer | <input type="checkbox"/> Spinal trauma/surgery |
| <input type="checkbox"/> Cholesterol problems | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Dislocations |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Ligament/Cartilage injuries |
| <input type="checkbox"/> Strokes | <input type="checkbox"/> Ankylosing Spondylitis | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psoriatic Arthritis | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> A pacemaker | <input type="checkbox"/> Reiter's Arthritis | <input type="checkbox"/> Hepatitis/HIV |
| <input type="checkbox"/> An aneurysm | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Blood Clotting Disorders |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Allergies to tape/creams | <input type="checkbox"/> Mental Illness |

Do you have full capacity to consent to treatment ? YES NO

I have read and understand the H P C Cancellation Policy, Privacy Policy, Office Policy and Informed Consent forms.

Name: _____ Signed: _____ Date: _____

The information you provide is not passed onto any other individual business or organisation.

Hyperdome Physiotherapy Centre mails out an informative newsletter with special offers. If you choose NOT to receive material from us please tick this box.