D'ARCY BAIN PHYSIOTHERAPY
We set the standard with care.

MEDICAL HISTORY

Name _____

The information requested below will enable us to treat you safely. If you have any questions about the information requested, please ask your health care professional (HCP). All information provided below will be kept confidential. Your written permission is required to release any information.

PLEASE CHECK ☑ ANY OF THE CONDITIONS YOU ARE EXPERIENCING OR HAVE EXPERIENCED:

[Cardiovascular]
- ❑ Cardiac Pacemaker
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Elevated Cholesterol
- ❑ Congestive Heart Failure
- ❑ Heart Attack
- ❑ Angina/Chest Pain
- ❑ Heart Disease
- ❑ Other Heart Problems

_____

[Head / Neck]
- ❑ Headaches (how often?)

_____
- ❑ Migraines (how often?)

_____
- ❑ Nausea/Vomiting
- ❑ Vertigo
- ❑ Dizziness
- ❑ Vision Problems/ Loss
- ❑ Double Vision
- ❑ Blurred Vision
- ❑ Ear Problems/Loss
- ❑ Difficulty Speaking
- ❑ Difficulty Swallowing

[Respiratory]
- ❑ Chronic cough
- ❑ Shortness of breath
- ❑ Bronchitis/Emphysema
- ❑ Asthma
- ❑ Other Respiratory Problems

_____

Do you smoke? ❑ Yes ❑ No

[Neurological]
- ❑ Stroke
- ❑ Traumatic Brain Injury
- ❑ Concussion/Head Trauma
- ❑ Multiple Sclerosis
- ❑ Parkinson's Disease
- ❑ Epilepsy/Seizures
- ❑ Loss of sensation (where):

_____
- ❑ Other Neurological Disorders

_____

[Gastro-Intestinal]
- ❑ Ulcer ❑ Hernia
- ❑ Gallbladder ❑ Liver Condition
- ❑ Kidney ❑ Bladder Condition
- ❑ Painful/Frequent Urination
- ❑ Crohn's/Colitis

[Other]
- ❑ Anxiety/Depression
- ❑ Cancer (Type)

_____
- ❑ Diabetes ❑ Type 1 ❑ Type 2
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Osteoporosis
- ❑ Fainting
- ❑ Connective Tissue Disorders
- ❑ Thyroid Disorder
- ❑ Blood Disorder
- ❑ Communicable Diseases (MRSA, TB, HIV, Herpes, Hepatitis)
- ❑ Allergies (what?)

_____
- ❑ Steroid treatment ❑ Injections

_____
- ❑ Internal pins, plates, or joint replacements? _____

_____

[Women]
- ❑ Pregnant, due date:

_____
- ❑ Incontinence ❑ Prolapse
- ❑ Menstrual Problems

Please List All Medications (Prescription/Non-Prescription):

_____

_____

_____

What made you decide to come to our clinic? (Check any that apply to you)

- ❑ Sent by Doctor
- ❑ Been to clinic before
- ❑ Sent by WCB/MPI
- ❑ Referred by friend/relative (name)

_____
- ❑ Workplace
- ❑ Last minute physio/massage
- ❑ Website
- ❑ Facebook/Instagram
- ❑ Google Listing/Review
- ❑ Radio/TV Advertisement
- ❑ Location/Signage
- ❑ Word of Mouth
- ❑ Other:

_____