Back in Balance
A centre for wellbeing

Physiotherapy Patient Information & Health History

The purpose of collecting this information is important in your physiotherapy evaluation process. This information is kept confidential and is a requirement by the College of Physiotherapists of Ontario who may inspect these records as part of their regulatory activities in the public interest.

Name: _____ Date: _____
Date of birth : _____Gender: ☐ Male ☐ Female ☐ Non-Binary
Address: _____ Apt. #: _____
City: _____ Province: _____ Postal Code: _____
Home Tel: _____ Work Tel: _____ Cell Tel: _____
Email address: _____ Occupation: _____

Please indicate your reminder preference: ☐ ***email*** ☐ ***phone call*** ☐ ***text*** ***If text, indicate cell carrier:*** _____
Would you like to subscribe to our monthly newsletter for stretches, chiropractic tips, and recipes? ☐ Yes ☐ No

In case of emergency contact:_____ Relationship:_____ Contact tel. _____
If under 18: Name of Parent 1: _____ Name of Parent 2: _____
Whom may we thank for recommending this practice? _____

Medical Doctor Name: _____ Clinic Name: _____
Address: _____ Phone number: _____
Are you currently seeing any other health providers for the same concern? ☐ Yes ☐ No
If yes, please list: _____
May we contact your healthcare provider(s) to update them on your care? ☐ Yes ☐ No

Females:
Have you been previously pregnant? ☐ Yes ☐ No Are you one year or less post partum? ☐ Yes ☐ No
Are you currently pregnant? ☐ Yes ☐ No If yes, due date: _____

Identify up to three (3) important activities that you are **unable to do or are having difficulty doing** as a result of your _____ problem. **Rate each** on a scale of 0 (unable to perform) to 10 (able to perform at same level as before injury/ problem). Note what makes it feel better &/or worse.

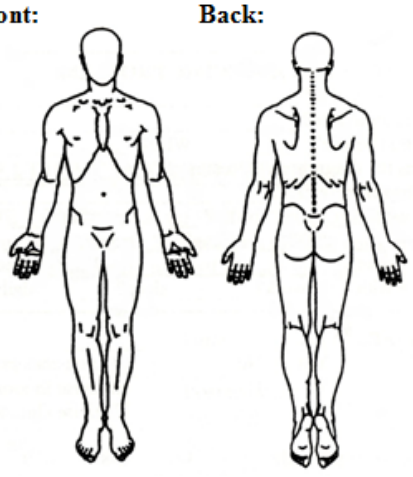
Activity (e.g. sit, stand, walk, run, bend, reach, etc.)	**Score of Ability:**	**What makes it better?**	**What makes it worse?**
1. _____	0 1 2 3 4 5 6 7 8 9 10	_____	_____
1. _____	0 1 2 3 4 5 6 7 8 9 10	_____	_____
1. _____	0 1 2 3 4 5 6 7 8 9 10	_____	_____

In the diagram below, please mark the areas on your body which best represents your current complaint(s) with the symbols indicated.

Symbols:

Numbness	≡≡≡	Pins & Needles	••• •••
Burning	x x x x x x	Stabbing & Sharp	//////
Dull & Aching	+++ +++	Stiff & Tight	2 2 2 2 2 2

Front: **Back:**



Date of initial history: _____ Update 1: _____ Update 2: _____

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An accurate and full health history is important to ensure your safety and an accurate diagnosis. Please notify your therapist of any changes in your health status. All information collected is confidential and will only be used or disclosed at your discretion.

Past abdominal surgeries: _____
Past pelvic surgeries: _____
Other past surgeries: _____
Please list any births, injuries, or traumas (including falls, accidents, etc.): _____
Please list any hospitalizations: _____
Please list any current medications and supplements (prescription & non-prescription): _____
_____

Please mark a "C" next to any condition or symptom which you are currently experiencing and a "P" next to any condition or symptom you have experienced in the past:

Soft tissue & Musculoskeletal:

	Pain or discomfort:	Other difficulty:
Neck	__	__
Upper back	__	__
Mid-back	__	__
Lower back	__	__
Shoulders	__	__
Chest/breast	__	__
Elbow	__	__
Wrist	__	__
Hand/fingers	__	__
Hip joint	__	__
Knee	__	__
Ankle	__	__
Foot & toes	__	__
Coccyx	__	__
Pubic bone	__	__
Sacroiliac	__	__

Immunological:
Allergies __
STI / STD __
Cancer __
Infections __
Hepatitis __
Other:_____

Respiratory:
Chronic cough __
Shortness of breath __
Bronchitis / emphysema __
Tuberculosis (active) __
Asthma __
Smoker __

Cardiovascular:
High / low blood pressure __
High cholesterol __
Heart attack __
Other: _____

Neurological:
Epilepsy __
Multiple sclerosis __
Stroke / CVA __
Concussion __
Altered sensation __
Sensitivities to light, touch, sound, smell, movement, etc. __

Endocrine:
Diabetes type: _____ __
Hyper / hypo-thyroid __
Fatigue __

Psychological, cognitive:
Anxiety __
Depression __
Stress __
Mood swings __
Brain fog __
Difficulty concentrating __

Head / Neck:
Headaches / migraines __
TMJ issues __
Eye problems (blurred, double, floaters, vision loss) __
Ear problems (tinnitus, etc.) __
Hearing loss __
Dizziness / fainting __

Urogynecological:
Urinary tract infections __
Urinary / fecal frequency, urgency, or incontinence __
Night time urination __
Pelvic organ prolapsed __
Interstitial cystitis __
Endometriosis or PCOS __
Pain with menses or PMS __
Irregular menstrual cycle __
Pain with intercourse __
Painful sexual arousal or climax __

Digestive:
Crohn's, celiac, u. colitis __
Constipation __
Diarrhea __
Bloat, nausea, vomiting, gas __
Reflux / heartburn __
Other: _____

Other:
Skin condition (e.g. eczema, acne, etc.) __
Arthritis / lupus / gout / active inflammatory condition __

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Lifestyle:
How we use and support ourselves in our everyday life contributes to our overall health profile. Please complete this section to provide me with more holistic information:

Please list any sensitivities (food, scents, noises, etc.): _____
Please list any activities (physical or otherwise) you are currently participating in, have stopped, or would like to return to:
_____
How do you feel **2 hours after** exercise? □ Nourished □ Depleted
How do you feel the **same night** after exercise? □ Nourished □ Depleted
How do you feel the **next morning** after exercise? □ Nourished □ Depleted
How would you rate your sleep? □ Poor □ Average □ Good List the average number of hours you sleep per night: ____
Do you have trouble falling or staying asleep? □ Yes □ No Do you wake feeling well rested? □ Yes □ No
Do you regularly use stimulants (i.e. caffeine, sugar, etc.) to combat daytime tiredness? □ Yes □ No
What do you do to reduce or relieve stress? _____ Does it help? □ Yes □ No

Please list one or two goals you hope to achieve with physiotherapy: _____
_____

Commitment to Physiotherapy:

So often I have heard that patients do not feel they have enough time with their healthcare provider. As such, my mission is to provide one-on-one physiotherapy services in a format that allows adequate time for quality and individualized evidence-informed, holistic care. In setting aside this significant time for your assessment, treatment and care, **I ask for a MINIMUM of 24 hours notice for all scheduling changes.** This responsible and respectful act will allow adequate time to reschedule your appointment, as well as notify and schedule other patients awaiting vital care.

While I understand that life sometimes brings unexpected events and you may need to cancel your appointment with short notice, those without a legitimate excuse will be **charged the full treatment fee** (and is up to the discretion of the care provider). This charge is not covered by insurance and will be the responsibility of the patient to pay. **Email & phone reminders are courtesy only.**

_____ _____

Patient Signature (or guardian, if under 18 years old) **Date** (DD/MM/YY)

Pelvic Floor Assessment & Treatment Patient Consent:

Pelvic Floor Physiotherapy will include an internal vaginal and/ or ano-rectal examination and treatment will include any combination of internal or external manual therapy, exercise program, and education. I, the undersigned patient, give my consent to undergo such assessment and treatment and know that I can withdraw my consent at any time and that I am free to bring an additional person to any treatment sessions to act as my advocate.

_____ _____

Patient Signature (or guardian, if under 18 years old) **Date** (DD/MM/YY)

Please initial to confirm that you have read our office fees and policies: _____