tower physio

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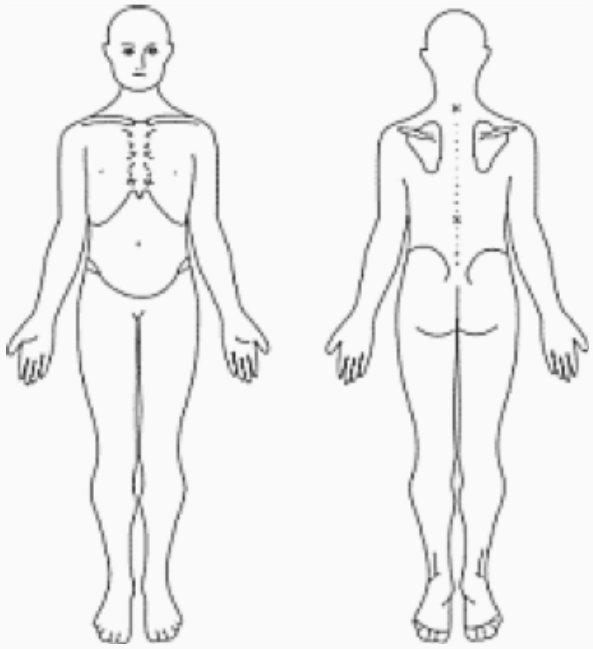
New Patient History Form

The first step in recovering from your injury is for us to know all about your pain and symptoms. Please assist your physiotherapist by answering the following questions as completely and accurately as possible. In order to provide you with safe and effective treatment, we also require knowledge of your past medical history.

Thank you for your cooperation. If you have any questions or concerns with any part of this form, you may leave it blank and ask your physiotherapist.

Name _____ Date _____

After printing out this form please shade in the areas of pain and/ or mark an X for any areas of numbness or pins and needles.



How long have you had this injury? _____

Was there an incident that brought on the problem?

☐ Yes - Please describe _____
☐ No
☐ Unsure

Please rate your level of pain over the **last 24 hours** on the pain scale below by marking an X on the line: **0** (no pain) and **10** (worst pain imaginable).

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10

Please circle the words below that describe your pain. (Choose 1 for each line)

☐ off and on *or* ☐ constant, 24 hours a day

☐ getting better *or* ☐ getting worse *or* ☐ just staying the same

☐ worse in the morning *or* ☐ worse when trying to sleep *or* ☐ both *or* ☐ no different

What makes your pain worse?

☐ Sitting ☐ standing ☐ walking ☐ other _____

What makes your pain better?

☐ Sitting ☐ standing ☐ exercise ☐ rest ☐ medication ☐ other _____

Do you experience any of the following?

Conditions/Symptoms	Yes	No	Past	Comments
Dizziness	☐	☐	☐	
Balance problems	☐	☐	☐	
Change in bladder or bowel function	☐	☐	☐	
Numbness in the face	☐	☐	☐	
Numbness in the groin region	☐	☐	☐	
Pain with coughing or sneezing	☐	☐	☐	

Have you had any investigative tests done for this injury (e.g. X-Ray, MRI, other)?

☐ Yes - Please describe _____

☐ No

Are you on any medications? If so please list:

_____

Past Medical History. Please select all of the following that apply to you (information will remain confidential):

☐ Heart disease	☐ Diabetes	☐ Circulatory Disorders
☐ Metal implants	☐ Pace maker	☐ Breathing disorders
☐ Osteoporosis	☐ Epilepsy	☐ Hepatitis A, B, C
☐ Pregnancy	☐ Cancer	☐ HIV/AIDS
☐ Steroids	☐ Bleeding disorder	☐ Other_____

Have you had any other injuries or trauma in the past? If so, please list:

Year: _____ Injury: _____

Year: _____ Injury: _____

Year: _____ Injury: _____

What is your occupation? _____

Please describe anything at work that influences your injury/pain (e.g. prolonged sitting, physical job demands, stress levels). _____

_____

What sports or activities do you like to do?

_____

Do you have access to a gym or gym equipment? (If yes, which facility?)

_____

Thank you again for filling out this form.

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