Physiotherapy - Adult

File #: _____

Date: _____

Waterdown Village Chiropractic & Wellness Group

255 Dundas Street East
Unit #14A
Waterdown, ON L8B 0E5
T 905·689·4440
F 905·689·4441
E info@wvchirogroup.ca

wvchirogroup.ca

General Information

How do you wish to be addressed in our office?

☐ First name ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.

How do you wish to be contacted by our office regarding your appointments?

☐ Email ☐ Phone

Last Name: _____ **D.O.B.** _____

First Name: _____ **Sex:** ☐ M ☐ F

Address: _____

Town/City: _____ **Province:** _____ **Postal Code:** _____

Home Phone: ( ) _____ **Cell Phone: ( )** _____

Email: _____ _____ **Please Initial** Consent to receive email communication from the clinic

Occupation: _____ **Spouse's name (if applicable):** _____

Children: Y N **Number:** _____ **Ages:** _____

(Females) Are you pregnant? Y N **How many weeks?** _____ **Estimated Due Date:** _____

Family Dr. Name: _____ **Phone: ( )** _____

Previous Wellness Care? (check all that apply)

☐ Chiropractic ☐ Physiotherapy ☐ Naturopathy ☐ Massage Therapy ☐ Osteopathy

Location: _____

Referred by: _____

How did you decide to choose our office? _____

Reason for consulting the office:

- ☐ I have a specific problem and require help only with this problem.
- ☐ After my specific problem has been relieved, I am interested in strategies for maintenance.
- ☐ After my specific problem has been resolved and I understand methods to ensure it does not return, I am interested in strategies to improve my general health.
- ☐ I have no symptoms and I feel well. I am interested in strategies to help me to continue to feel well, or even better.

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Health History

A detailed history can give your physiotherapist valuable insight into the wellness condition of your body. Your health history includes your journey from childhood to present. Please take the time to **fully complete** this form to the best of your ability:

A. Health Symptoms

Health symptoms often appear after years of underlying dysfunction. Please briefly describe any current painful symptoms you are experiencing: _____

_____

How long ago did the problem start? _____

The pain you experience is: CONSTANT INTERMITTENT

What aggravates your pain or problem? _____

What relieves your pain or problem? _____

Does your pain radiate or travel to other parts of your body? Y N

Does your condition get worse at certain times of the day or night? _____

How long does the pain last when you get the pain? _____

Is your condition: WORSENING IMPROVING

Have you consulted other health professionals regarding this problem? Y N

If yes, which ones? _____

File #: _____

B. Current Health Status (Please circle either Y or N)

Y N **Have you had any past surgeries? If so, what?** _____

Y N **Do you smoke or have you smoked in the past? Date quit:** _____

Y N **Do you drink any alcohol? If so, how much/week?** _____

Y N **Do you feel that you have an adequate diet, especially vegetables?**

Y N **Do you suffer from disturbed sleep?**

Y N **Have you ever been in a motor vehicle collision (include minor ones)?**

Explain: _____

Y N **Have you had any other accidents, trauma or fractures?**

Explain: _____

Y N **Previously diagnosed medical conditions? List:** _____

_____

Y N **Drugs / Prescription / Over the Counter / Recreational / Birth Control**

If yes, list drug and condition: _____

_____

Y N **Regular Exercise?** Aerobic/Non-aerobic _____ x/Week

Stress: Occupational _____ Physical _____ Mental _____

Sleeping Posture: Back _____ Front _____ Side _____ Hours of Sleep _____ /Night

<u>Expectations</u>:

Please list your top 3 expectations that you have regarding your care at Waterdown Village Chiropractic & Wellness Group:

1. _____
2. _____
3. _____

File #: _____

Please check a box if you currently experience, or have had a problem with, any of these:

- ☐ Headaches
- ☐ Neck pain
- ☐ Back pain
- ☐ Sleeping problems
- ☐ Stress
- ☐ Irritability
- ☐ Chest pains
- ☐ Dizziness
- ☐ Stiff neck
- ☐ Pins & needles in legs
- ☐ Pins & needles in arms
- ☐ Numbness in fingers
- ☐ Painful menstruation
- ☐ Dental problems
- ☐ Numbness in toes
- ☐ Shortness of breath
- ☐ Fatigue
- ☐ Stroke
- ☐ Memory loss
- ☐ Ringing in ears
- ☐ Ear infections
- ☐ Heart trouble
- ☐ Circulation problems
- ☐ Loss of balance
- ☐ Fainting
- ☐ Anxiety
- ☐ Depression
- ☐ Hearing problems
- ☐ Loss of taste
- ☐ Diarrhea
- ☐ Stomach upset
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Cold sweats
- ☐ Fever
- ☐ Prostate problems
- ☐ Hepatitis B
- ☐ HIV
- ☐ Trouble with bowel or bladder control
- ☐ Reproductive problems (endometriosis, fibroids, impotence, etc.)

Family History of: Heart Disease _____ Stroke _____ Cancer _____ Diabetes _____

Other: _____

_____

_____