****605 – 8th Ave, SW Name:\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Calgary, AB, T2P 0A4

T. 403-455-4010 Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

F. 403-455-4030

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**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.**

**On the diagram, 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? \_\_\_\_\_\_No \_\_\_\_\_\_Unsure

\_\_\_\_Yes. Please describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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) 10 (worse pain imaginable)
 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 0 1 2 3 4 5 6 7 8 9 10

**What makes your pain worse?** 1) Sitting 2) standing 3) walking 4) other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What makes your pain better?** 1) Sitting 2) standing 3) exercise 4) rest 5) 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)?** \_\_\_\_\_\_No\_\_\_\_\_Yes Please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Past Medical History.** Please indicate with an (X) 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, relevant surgeries 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 or pain (stress, prolonged sitting, lifting, etc.) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What sports or activities do you like to do? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your primary goal for attending physiotherapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thank you again for filling out this form.
Calgary Core Physiotherapy