

Health Questionnaire

Name: _____

Date of Birth: _____

Male ___ Female ___

Date of onset of symptoms _____

How did your injury occur?: _____

Employer: _____

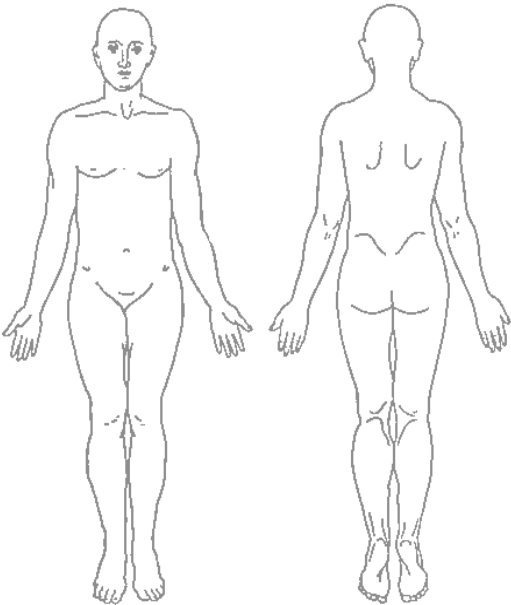
Occupation: _____

Are you off work at present? _____

X-Rays: _____

Medications: _____

Mark areas of pain below with ///////////////
Mark tingling or numbness with xxxxxxxx



Check if you have been diagnosed with, or experience any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Reiter's Disease |
| <input type="checkbox"/> Ankylosing Spondylitis | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> HIV/Hepatitis | |
| <input type="checkbox"/> Diagnosed Cancer (past/present) | |
| <input type="checkbox"/> Prolonged indigestion | |
| <input type="checkbox"/> Night sweats | |
| <input type="checkbox"/> Unexplained weight loss | |
| <input type="checkbox"/> Constant night pain | |
| <input type="checkbox"/> Heart condition | |
| <input type="checkbox"/> Chest pain/shortness of breath | |
| <input type="checkbox"/> Smoking (past or present) | |
| <input type="checkbox"/> Thyroid problems | |
| <input type="checkbox"/> Memory or concentration difficulties | |
| <input type="checkbox"/> Allergies (_____) | |

PLEASE READ CAREFULLY

It is Dynamic Physiotherapy's goal to provide our clients with optimal therapeutic care, to help minimize symptoms and maximize physical function. In some cases where the consequences of injury are irreversible, we will strive to educate you how to best manage your condition, and will inform you of other safe care options.

I understand that it may be necessary for the therapist to communicate and consult with my physician and/or adjuster in order for me to receive the optimal level of care. I acknowledge that success of the treatment is due in part to my following of instructions and exercises prescribed to me by the therapist. I understand that I have the right to refuse any part of treatment I am uncomfortable with, and will inform the therapist of any concerns I have.

I have reviewed Dynamic Physiotherapy's cancellation policy.
I consent to receive assessment and treatment at Dynamic Physiotherapy.

Signature

Date