Fifth Avenue Place
Chiropractic & Massage Therapy

Chiropractic ♦ Physiotherapy ♦ Massage Therapy ♦ Acupuncture

♦ Zeel Patel, PT ♦

Name:_____ Date:_____

Address: _____

Phone #:_____ E-mail:_____

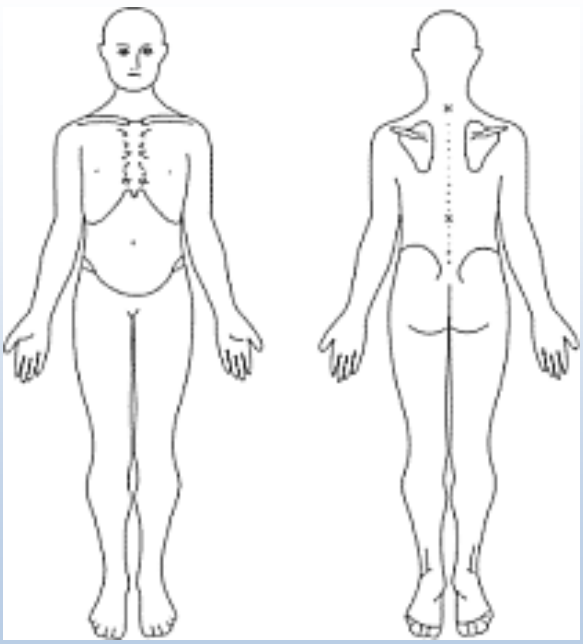
Birthday _____ Emergency Contact: _____
Month/Day/Year Name and phone#

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? Yes _____ No _____ Unsure _____

If 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)? Yes _____ No _____

If yes; please describe: _____

Past Medical History. Please indicate with an (X) the following that apply to you (information will remain confidential):

_____Heart disease
_____Metal implants
_____Osteoporosis
_____Pregnancy
_____Steroids
_____Diabetes
_____Pace maker
_____Epilepsy
_____Cancer
_____Bleeding disorder
_____Circulatory Disorders
_____Breathing disorders
_____Hepatitis A, B, C
_____HIV/AIDS
_____Other_____

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

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.

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INFORMED CONSENT for PHYSIOTHERAPY

Please Read Carefully

I, undersigned, do hereby give my voluntary consent for the administration of Physiotherapy deemed appropriate by my treating Physiotherapist.

I understand that Physiotherapy treatments may include an individualized exercise prescription and various forms of manual therapy techniques such as mobilization, manipulation, soft tissue release and stretches. Treatments may also include modalities such as heat, ice, therapeutic taping, ultrasound, laser, TENS, interferential current, shock wave and electric muscular stimulation. Other treatment options include acupuncture/dry needling, that involve the insertion of single use, sterile, disposable needles through the skin, into the underlying muscles.

I understand that the primary goals of Physiotherapy treatments are to help reduce my pain and improve my mobility, strength, endurance, function and quality of life.

I understand that there are very small possibilities of risks or complications that may result from the above listed treatments. I do not expect the Physiotherapist to anticipate all the possible risks and complications. I wish to rely on the Physiotherapist to exercise proper judgment during the course of treatment to make decisions based upon my best interest.

Potential small but possible risk factors:

Manual therapy: Joint and/or muscle soreness

Exercise therapy: Joint and/or muscle soreness

Electrical/Shockwave modalities: Minor skin irritations such as redness or rash

Therapeutic Taping: Minor skin irritations such as redness or rash

Acupuncture/Dry Needling: Minor soreness, bleeding or bruising, nausea, fainting, infection, shock convulsions, possible perforation of internal organs, stuck or bend needles, and fetal distress in pregnant women

I will immediately notify the Physiotherapist of any changes in my pregnancy or medical status. I will have the opportunity to discuss with my Physiotherapy the nature and purposes of all my treatments. I accept the fact that there is no guarantee of the effectiveness of the treatment. I am aware that I may withdraw this consent and discontinue treatment at any time.

I consent to the Physiotherapy treatments offered or recommended to me by my Physiotherapist(s). I intend this consent to apply to all my present and future Physiotherapy care.

_____ _____ _____

Name (please print) Signature Date