Fifth Avenue Place
Chiropractic & Massage Therapy

Chiropractic ♦ Physiotherapy ♦ Massage Therapy ♦ Acupuncture

♦ Waldo Cheung, MPT, MSC BKIN ♦

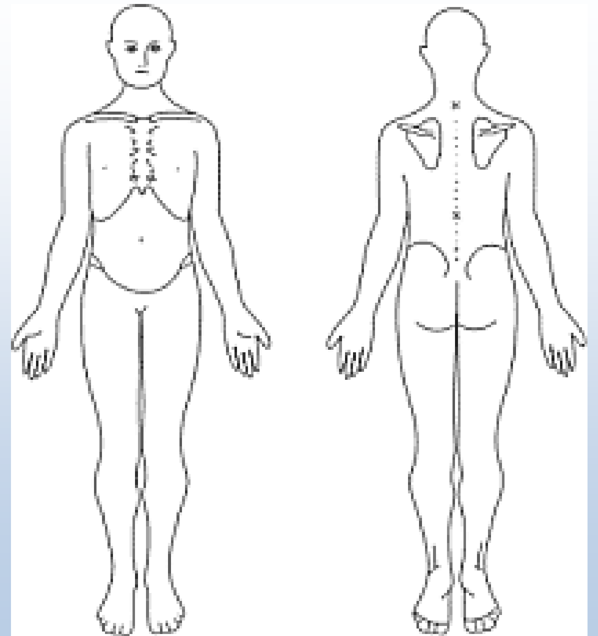
Name:___________________________________ Date:____________________________________

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.



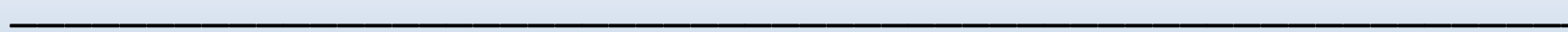
How long have you had this injury? ____

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: ____

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.