

PHYSIOTHERAPY

Confidential Patient Case History Form

Name: _____ Birthdate: (Day) _____ (Month) _____ (Year) _____

Email: _____ Home Phone: _____ Cell: _____

Physician: _____ Has your physician seen you for your current problem? Yes No

Names of other Healthcare Providers you are seeing for your problem:

I currently have, or in the past had the following health issues (check all that apply):

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Stroke | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Falling Spells | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Bladder Incontinence | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Fibromyalgia/Chronic fatigue | <input type="checkbox"/> Bowel Incontinence | <input type="checkbox"/> Depression | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Diabetes Type _____ | <input type="checkbox"/> IBS | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Current Smoker |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> IUD | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Mood Disorder | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Migraines/Headaches | <input type="checkbox"/> Chronic Constipation | <input type="checkbox"/> ADHD | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Epilepsy/seizure | <input type="checkbox"/> Hiatal Hernia |
| | <input type="checkbox"/> High Blood Pressure | | <input type="checkbox"/> Hearing loss |

 Neurological Condition (Specify): _____ Cancer – Specify type, treatment undergone and approximate year: _____

 Learning difficulties (specify): _____ Other: _____

Are you currently pregnant? Yes No

Please list ALL previous surgeries and (approximate) year they occurred:

Please list ALL previous sustained injuries (e.g. car accident, falls, concussions, fractures, etc.) and approximate year they occurred:

Please list all medications/supplements and reasons for taking them:

What are your goals/expectations for treatment?

Please list any other information you feel would assist us in ensuring your safety and optimize your care:

The physiotherapist met with me, the client, to discuss my medical history. I understand the nature, benefits, potential risks, alternatives and consequences and agree with the outcome of this discussion and treatment. I give consent for my treatment notes to be available to all health care professionals at River Stone Wellness Centre.

For insured clients:

I hereby consent to direct billing so that River Stone Wellness Centre may bill my health insurance company and have that company pay River Stone directly for my treatments. By signing this I also state that I will pay any outstanding fees for treatments received that are not covered by my insurance company.

Cancellation:

We require 24 hours' notice if you need to cancel/change your appointment so that we may accommodate another client in need of our therapeutic services. If you cancel with less than 24 hours' notice, a \$50.00 cancellation fee will be charged to your account and/or credit card. We hold encrypted credit card information on our secure server. If you forget or otherwise choose to forgo your appointment, we reserve the right to charge in full for your missed appointment.

Client Signature

Date

Physiotherapist Signature