Joyce Clark Physiotherapy

Case History

Date: ____________________

Name: ____________________

Address: ____________________

City____________________ Prov__________ Postal code__________

Phone: Home ( ) ____________________ Marital status : M S W D

Work ( ) ____________________ Sex: M F

Cell ( ) ____________________ Ht: ________ Wt: __________

Date of birth: day__________ month__________ year__________

Occupation: ____________________

Medical Doctor: ____________________

PRESENT CONDITION AND HISTORY

What is your chief concern? ____________________

When did this issue start ? Was it the result of a specific incident ? ____________________

Are there other problems related to your chief concern ? ____________________

Do you currently do anything that helps you to feel better ? ____________________

Do you currently avoid anything so that you can feel better ? ____________________

What (if anything) seems to make your problem worse ? ____________________

Please list any previous accidents, falls, fractures: ____________________

Please list any surgical procedures with dates: ____________________

What medications or supplements are you currently taking ? ____________________

Please list any x rays, CAT scans and their results that are relevant to your chief concern: ____________________

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Are there any functional restrictions for you at work or at home? ____________________________

____

What recreational activities did you do before your chief concern arose ?____________________

____

What recreational activities do you do now ? ______________________________________

____

What is your goal with therapy ?____

____

GENERAL SYMPTOMS

(Please mark with a check for those that CURRENTLY apply)

Fever ______ Muscle spasms ______ Depression _____
Arthritis ______ Exercise Intolerance _______ Anxiety ______
Allergies ______ Fatigue _______ Use of corticosteroids past ___present___
Cold sensitivity _____ Poor temperature regulation ___ Exercise intolerance ________
Difficulty swallowing ____ Ear aches _________ Ringing in ears ________
Dizziness _______ Jaw clicking _________ Use of blood thinner: past ___ present_____
Coughing____________ Difficulty breathing ___________ Asthma ________
Indigestion _____ Nausea _____ Vomiting _____Constipation _____Diarrhea _____ Ulcers _____
Incontinence (fecal)_____ Incontinence (urine) _______ Numbness in saddle area _________
Fatigue ________ Stress at home_________ Stress at work______
Cancer: past _____present_____ HIV ______ Diabetes______ _Rheumatoid arthritis _______
Epilepsy /Seizures_____ Cerebral Palsy _______ Multiple sclerosis ______ Stroke ______
Heart condition (please specify) ____________________Learning disability ___________________
Numbness/tingling (specify location)____
Tendonitis (specify location) ____
Joint instability (specify location)____
Sprain or strain (specify location) ____
Headaches (migraine) _____ other headaches ________
For women: Pregnancy past ?______ if yes, ages of children_________presently pregnant _____/weeks
: Painful periods ________ PMS_________Endometriosis _________
Muscle or Joint Pain: Neck ___ Mid back_____ Low back__ Shoulder right ___left ____
Elbow right___left___ Wrist right____left____ Hip right _____left_____ Knee/leg right______left____
Ankle right _____left_____ Foot right _____left ______Jaw right _____left ______

Please list any conditions or diseases that you may have that have not already been listed:__________

____

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Is there anything else about your health that you would like to mention ?______________________

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