GoodPractice
Physiotherapy

Confidential Case History Form

Date: _____

Name: _____ Email: _____

Address: _____

City: _____ Postal Code: _____

Telephone: (H) _____ (C) _____ (W) _____

Date of birth: _____ Sex: ☐ Male ☐ Female

Occupation: _____

Referral: ☐ GP ☐ Ortho ☐ Self ☐ Other: _____

Family physician: _____ City: _____

Nature of your complaint (ie: shoulder, neck, back, etc.): _____

Type of pain (ie: dull ache, sharp, throb, etc.): _____

Are you presently taking any medications? If yes, please list: _____

Have you had recent (last 5 years) or major surgery? ☐ Yes ☐ No _____

Have you had unexplained weight loss? ☐ Yes ☐ No _____

Have you been in any motor vehicle accidents? ☐ Yes ☐ No Date: _____

Are you attending because of a work place injury? ☐ Yes ☐ No Date: _____

GENERAL HEALTH (mark only those that apply):

_____ Bladder: ☐ Normal ☐ Abnormal
_____ Infectious skin conditions
_____ Tuberculosis
_____ Hepatitis
_____ HIV

_____ Allergies: Type _____
_____ Cancer
_____ Digestive disorders: Type _____
_____ Epilepsy
_____ Hemophilia
_____ Hypoglycemia
_____ Pins, plates, prosthesis

_____ Chronic cough
_____ Bronchitis
_____ Shortness of breath
_____ Asthma
_____ Ephysema

_____ High blood pressure
_____ Low blood pressure
_____ Congestive heart failure
_____ Heart disease
_____ Heart attack: When? _____
_____ Stroke: When? _____
_____ Pacemaker or similar device

_____ Arthritis
_____ Diabetes
_____ Dizziness
_____ Ear aches
_____ Hernia
_____ Headaches: Type _____
_____ Vision or hearing loss
_____ Loss of sensation

Women
_____ Pregnant
_____ Number of children
_____ Painful menstruation
_____ Menopause

Signature: _____

Consent to Collect and Disclose Personal Information

I grant permission for Good Practice Physiotherapy to contact my physician, naturopathic physician, chiropractor, osteopathic manual therapist, massage therapist or other health care provider for the purpose of sharing information with which to enhance my treatment program.

I hereby consent to receiving appointment reminder notices via email or telephone. However, I also realize that reminders are a *courtesy* only and that I, as a patient, am responsible to attend all scheduled appointments or give 24 hours notice of cancellation. I also consent to receiving e-mails 1-4 times per year regarding health courses being offered to patients of Good Practice Physiotherapy.

I accept that I am ultimately responsible for the payment of all fees for any treatments, services, reports, etc. incurred in the course of treatment. I also understand that I will be charged $30 for appointments missed without advance notice of at least 24 hours.

Date:_____ Patient Signature: _____