

PHYSIOTHERAPY MEDICAL HISTORY FORM

Surname: _____ First Name: _____
 Date of Birth (M/D/Y): _____ Age: _____ Sex : _ F _ M
 Physician: _____ Alternate Care Provider(s): _____
 Has your physician seen you for your current problem? Yes ☐ No ☐
 Have any other care providers seen you for your current problem? Yes ☐ No ☐
 Please list who you have seen: _____

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

- | | |
|---|---|
| ☐ Arthritis (osteoarthritis) | ☐ Dizziness |
| ☐ Rheumatoid Arthritis | ☐ Allergies |
| ☐ Osteoporosis | ☐ Bowel Incontinence |
| ☐ Fibromyalgia/Chronic Fatigue | ☐ IBS |
| ☐ Headaches/Migraines | ☐ Chron's or Colitis |
| ☐ Epilepsy/Seizures | ☐ Celiac Disease |
| ☐ History of Falls | ☐ Hernia – Type _____ |
| ☐ Diabetes – Type _____ | ☐ Skin Condition |
| ☐ Thyroid Problems | ☐ Chronic Constipation |
| ☐ High Cholesterol | ☐ Bladder Incontinence |
| ☐ High Blood Pressure | ☐ Recurrent Urinary Infections |
| ☐ Coronary Heart Disease | ☐ Sexual Problems |
| ☐ Stroke | ☐ Depression |
| ☐ Pacemaker | ☐ Anxiety |
| ☐ Heart Attack | ☐ Mood Disorder |
| ☐ Asthma | ☐ Substance Abuse |
| ☐ COPD | ☐ Smoker (previous or current) |
| ☐ Fainting Spells | |
| ☐ Infectious disease or condition (ex. hepatitis, HIV, Herpes, Chlamydia, etc.). | |
| o Please name: _____ | |
| ☐ Neurological Condition - Please Describe: _____ | |
| ☐ Cancer – Please describe (including type, treatment and year): _____ | |

WOMEN ONLY

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

- Currently Pregnant Yes ☐ No ☐
- ☐ Miscarriage
- ☐ Menstrual Difficulties – Please Describe: _____
- ☐ Menopause – Please Describe Transition and Date: _____
- ☐ IUD
- ☐ Tubal Ligation
- ☐ Hysterectomy

Please list ALL previous surgeries (any part of the body) and the year they occurred:

Nurture Her Inc.
9505 163 Street NW
Edmonton, AB T5P 3M6
(780) 278-2004
www.nurtureher.ca



Name: _____ **Date of Birth:** _____

Please list ALL previous injuries (any part of the body) and the year they occurred (ex. car accident, fall, concussion, fracture, sprain/strain, etc.):

Please list ALL medications/supplements and reasons for taking them: (attach another page if necessary)

What are your goals and expectations for treatment?

Is there any other information you would like to share? Please list anything that might help improve your care and safety:

Patient Signature

Please sign in the presence of your therapist

Date

For Office Use Only:

- ☐ I have discussed this medical history with the client. The client indicated that she understood the nature, benefits, potential risks, alternatives, and consequences related to physiotherapy assessment and treatment, and that she agrees with the outcome of this discussion.

Therapist Initials

Name: _____ Date of Birth: _____

HEALTH QUESTIONNAIRE:

I go to sleep easily: Yes ☐ No ☐ I sleep well: Yes ☐ No ☐

I get enough sleep: Yes ☐ No ☐

On average I sleep _____ hours a night.

I have significant stress in my life: Yes ☐ No ☐

I have strategies for managing my stress: Yes ☐ No ☐

My stress management strategies are: (please list):

I like to exercise regularly: Yes ☐ No ☐

Check all that apply:

☐ At the Gym

☐ Exercise Classes

☐ Yoga

☐ Other: (Please Describe) _____

☐ Home Exercises

☐ Walking

☐ Running

I am optimistic that my condition will improve: Yes ☐ No ☐

Please name 3 activities that you are having difficulty performing along with their % level of difficulty:

(0% - unable to do the activity → 100% = able to perform at the same level as before the problem started)

Activity	→	Functional Level (0-100%)
1. _____	→	_____
2. _____	→	_____
3. _____	→	_____

ABILITY QUESTIONNAIRE:

It is important for your therapist to understand how much your condition/problems are affecting your life. For each topic, please circle or highlight the number that best describes your *current* ability.

1. **Family/Home Responsibilities:** This includes chores and duties performed around the house – like yard work, cleaning, errands or favours for other family members (ex. driving children)

Severe Inability 0 1 2 3 4 5 6 7 8 9 10 Full Ability

2. **Recreation:** This includes hobbies, sports and other leisure/fun activities

Severe Inability 0 1 2 3 4 5 6 7 8 9 10 Full Ability

3. **Social Activities:** Activities that involve participation with friends other than family members (ex. parties, theater, concerts, dining out and other social functions)

Severe Inability 0 1 2 3 4 5 6 7 8 9 10 Full Ability

4. **Occupation:** Activities that relate directly to paid or unpaid work (ex. home maker or volunteer)

Severe Inability 0 1 2 3 4 5 6 7 8 9 10 Full Ability

5. **Self Care:** This includes personal maintenance and independent activities of daily life such as dressing, taking a shower, etc.

Severe Inability 0 1 2 3 4 5 6 7 8 9 10 Full Ability