Total physiocare

CONFIDENTIAL PATIENT CASE HISTORY

First Name: _____ Last Name: _____

#1. What service are you here for?

☐ Physiotherapy ☐ Exercise Physiology

☐ Massage / Myotherapy ☐ Osteopath

#2. What is your major complaint?

_____

#3. How long have you had this problem? _____

#4. Have you had this problem or something similar in the past? Y / N

#5. Are you experiencing pain? Y / N

If Yes, what type of pain?

☐ Constant ☐ Intensity varies ☐ Sharp ☐ Travels

☐ Comes and goes ☐ Intensity does not vary ☐ Shooting ☐ Radiates

#6. Are you experiencing:

☐ Pins & needles ☐ Tingling ☐ Numbness ☐ Weakness

#7. Since the problem started, is your pain:

☐ About the same ☐ Getting Better ☐ Getting Worse

#8. What makes your pain worse

☐ Sitting ☐ Standing up from a chair ☐ Walking ☐ Other

#9. Does your pain interfere with:

☐ Work ☐ Sleep ☐ Hobbies ☐ Leisure

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#10. Have you seen other health professionals for this problem? Y / N
(includes other medical doctors, specialists / surgeon / chiropractor / osteopath)

If yes, please list:

_____

_____

#11. Are you currently on any medications? Y / N
If yes, please list:

_____

_____

#12. Have you ever taken oral Cortisone or Prednisolone? Y / N
(includes asthma medications such as Pulmicort, Symbicort, Flixotide & Seretide)

If yes, please list: _____

#13. Do you suffer any allergies? Y / N
If yes, please list: _____

#14. Are you pregnant? Y / N

#15. Do you have a cardiac pacemaker? Y / N

#16. Do you have or have you ever had? (please tick)

☐ High / Low Blood Pressure	☐ Cancer	☐ Spinal Trauma
☐ Heart Attack	☐ Heart Problems	☐ Osteoporosis
☐ Rheumatoid Arthritis	☐ Psoriatic Arthritis	☐ Ankylosing Spondylitis
☐ Stroke	☐ Diabetes	☐ Aneurysm
☐ Dislocations	☐ Ligament Injuries	☐ Cartilage Injuries
☐ Osteoarthritis	☐ Dizziness	☐ Headaches

Patient's Signature: _____ **Print Name:** _____

Physiotherapist Signature: _____ **Date:** DD / MM / YYYY _____