MedRehab PHYSIOTHERAPY

MEDICAL HISTORY

(Please Circle Yes or No)

Yes	No	Has your doctor ever said that you have heart trouble?
Yes	No	Do you frequently have pains in your heart or chest?
Yes	No	Do you have a history of asthma, emphysema or TB?
Yes	No	Did you have a recent viral infection?
Yes	No	Do you have diabetes?
Yes	No	Have you ever had high or low blood pressure?
Yes	No	Have you had or do you have cancer?
		If yes, what kind/where _____
Yes	No	Do you have epilepsy or have you ever had a seizure?
Yes	No	Do you have any skin conditions?
Yes	No	Do you have allergies?
Yes	No	Are you currently taking any medication?
		If yes, which _____
Yes	No	Is there medication that you should be taking, but are not?
Yes	No	Are you aware through your own experience or doctor's advise of any reason why you should not exercise without medical approval?
Yes	No	Have you been hospitalized within the last 12 months?
Yes	No	Have you ever had surgery? If so, where on your body? _____
Yes	No	Have you ever had a fracture?
Yes	No	Have you ever been in a motor vehicle accident or had WSIB injuries?
Yes	No	Are you pregnant?

What is the main issue you wish to be treated for? _____

Is there any other medical issue we should be aware of? _____

On a scale of 0 to 10, please rate your pain:

0 No pain	1	2	3	4	5 Moderate	6	7	8	9	10 Severe

Patient Signature: _____

Witness: _____

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