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| **MBS FITNESS & REHABILITATION**  8461 Keele Street, Vaughan, ON, L4K 1Z6  PH (647) 524 4690  An accurate health history is important to ensure that it is safe for you to receive a physiotherapy treatment. If your health status changes in the future, please let us know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.  Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code \_\_\_\_\_\_\_\_\_\_\_\_\_  Home # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  How did you hear about the clinic? flyer\_\_ friend\_\_ phone book \_\_ walk-by\_\_ other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ email me newsletters? \_\_\_ yes \_\_\_ no  Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Primary reason for seeking Physiotherapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Please indicate conditions you have or are having: | | | |
| **LOCATION OF PAIN/DISCOMFORT**   * Neck * Low Back * Mid Back * Upper Back * Shoulders * Arms * Legs * Knees   **HEAD/NECK**   * History of headaches * History of migraines * Vision problems/loss * Hearing problems/loss | **CARDIOVASCULAR**   * High blood pressure * Low blood pressure * Heart attack * Stroke/CVA * Phlebitis/varicose veins * Chronic congestive heart failure * Pacemaker or similar * Heart disease   **RESPIRATORY**   * Chronic cough * Shortness of breath * Bronchitis * Asthma * Emphysema | | **WOMEN ONLY**   * Pregnant; due\_\_\_\_\_\_\_\_\_\_\_\_\_ * Gynaecological conditions   **INFECTIONS**   * Hepatitis * TB * HIV   **OTHER CONDITIONS**   * Diabetes; onset\_\_\_\_\_\_\_\_\_\_\_ * Epilepsy * Cancer; onset\_\_\_\_\_\_\_\_\_\_\_\_\_ * Fibromyalgia * Constipation * Haemophilia * Arthritis; where?\_\_\_\_\_\_\_\_\_\_\_ * Skin conditions * Exema |
| **CURRENT MEDICATIONS:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **CONDITIONS IT TREATS**:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **SURGERY-DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **NATURE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **INJURY-DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **NATURE:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **OTHER MEDICAL CONDITIONS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | **PRIMARY CARE PHYSICIAN?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **PHONE:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **PRESENT INVOLVEMENT IN OTHER HEALTH CARE (CHIRO, PHYSIO ETC):**  \_\_\_\_\_ YES \_\_\_\_\_NO  **IF YES, WHAT FOR?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| I Understand that if I do not give at least 24 hours notice of cancellation of my appointment or do not show up for a scheduled appointment, I will be charged for the service.  **Consent to receive Physiotherapy treatment:**    **SIGN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | |