CROSSFIT SQUAMISH
Physiotherapy Health History

Name:______________________________ Birthday_____/_____/_____ Today's Date:______________
M D Y

Address:____

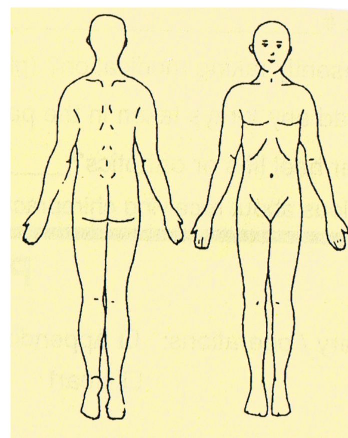
Phone: (home)__________________________ (cell)_________________________

Occupation/ Employer:____

How did you hear about our clinic? ❐ CFS Client ❐ Our Website ❐ Friend _________________

❐ Health Care Practitioner_________________ ❐ Other ______________________________

Please show location*



*What is/are your primary concern(s)? ______________________________

____

*What are you goals? What do you hope to achieve with physiotherapy? ___

____

____

*When/how did it start?____

____

____

*What **Aggravates** it? ____

*What **Relieves** it?____

*Major Illnesses/Surgeries/Accidents/Injuries	Date
______________________________________	____________________
______________________________________	____________________
______________________________________	____________________
______________________________________	____________________

*Is this visit related to an open: WCB case _______ or ICBC_______ case? Accident date? ___________

*Family Physician _____________________ Telephone ______________ Last Visit ________________

*Current Medications (name and what for) ____

*What **HEALTH CARE** treatments do you use? (circle PAST or CURRENT, and write who you see)

Physio: P / C ______________________ Date of last treatment**:** ___________________

Massage: P / C ____________________ **Chiro: P / C** _________________________

Naturopath: P / C __________________ **Acupuncture: P / C** __________________

Other: P / C ____

Consent to treatment:
Treatment techniques may include, but are not limited to: soft tissue techniques, manual techniques, spinal manipulation, acupuncture, intramuscular stimulation (IMS) and exercise. A number of these may be recommended during your treatment. Your therapist will explain to you the benefits, as well as any side effects for each chosen technique. If you have any questions or concerns about either your assessment or treatment, please discuss this with your therapist. You may withdraw consent for any procedure at any time by informing your therapist. Please initial this to say that you understand that you are consenting to assessment and treatment and that you will inform your therapist at any time if that consent changes.
_______ (initials)

PLEASE CHECK ANY OF THE FOLLOWING THAT ARE RELEVANT TO YOU IN THE PAST OR PRESENT

- ❑ Contact Lenses/glasses
- ❑ Blurred Vision
- ❑ Dizziness
- ❑ Low Blood Pressure
- ❑ High Blood Pressure
- ❑ Varicose Veins
- ❑ Constipation/Difficult bowel movements
- ❑ Shortness of Breath
- ❑ Phlebitis (inflam. of veins)
- ❑ Hardening of Arteries
- ❑ Muscle Cramps
- ❑ Lump in Throat
- ❑ Heart Conditions
- ❑ Respiratory Conditions
- ❑ Diabetes: Type 1 or 2? __
- ❑ Menstrual Problems
- ❑ Acute Inflamed Areas
- ❑ Cancer
- ❑ Aneurysm
- ❑ Blood Clots/D.V.T.
- ❑ Haemophilia
- ❑ Steel Pins/plates: where? _________
- ❑ Artificial Joints___________
- ❑ Tumors, Cysts
- ❑ AIDS/HIV
- ❑ Recent Infections
- ❑ Intestinal Problems
- ❑ Bruise Easily
- ❑ Loss of Skin Sensation/ Tingling
- ❑ Skin Disease
- ❑ Contagious Diseases
- ❑ V.D./S.T.D
- ❑ Pregnant (Weeks______)
- ❑ Other_________________ _ _________________________
- ❑ Allergies_______________ _________________________

YOUR APPOINTMENT time is reserved especially for you and may include time for assessment and homecare. If you need to reschedule or cancel an appointment, 24 hours notice is required so we may give this time to someone else. Otherwise it will be necessary to charge you for time lost. THANK YOU for your understanding!

I agree to pay for any appointment I miss, barring emergencies:

Signed:____ Date:________________