VC Therapeutics

Confidential Patient Information

*I understand that the information which I give on these forms is **confidential** and will be used for no other purpose than the Physiotherapy/RMT clinic records.*

*Name_____(First)_____(Last)_____*Date(dd/mm/yy)_____

*Date of Birth (dd/mm/yy)_____Age_____Gender □M □F

*Address_____*City_____*Postal Code_____

*Home Phone # (_____)_____Cell Phone #(_____)_____

Business Phone#(_____)_____E-mail_____

Employer_____Occupation_____

How did you hear about us? □Friend □Yellow Pages □Road Side Sign □Other _____

***What is your primary complaint?**_____

*Is your injury (complaint) due to: *(please put an* **X** *where applicable, if none apply, please leave blank)*

a:_____Personal Injury

b:_____Car Accident_____
Date of Accident

c:_____Work related injury/accident(WSIB)_____
Date Injured/ of Accident

Primary Health Care Practitioner:

Family Medical Doctor_____Phone #(_____)_____

Address_____

Date of last appointment_____Date of last physical_____

Please list any other Medical Doctor(s) consulted with in the last year:

Name of Dr_____Diagnosis_____

Name of Dr_____Diagnosis_____

***denotes required information**

*Patient Name*_____*DOB*_____

*Practitioner Name*_____*Date*_____

VC Therapeutics

Current Health Condition(s)

Current Complaint(s) **purpose of this appointment**_____

Are you being treated for this complaint by any other Doctors/Therapists? ☐Yes ☐No

If answered 'Yes' to the above,

Who?_____Type of Treatment_____Results_____

When did the condition begin?_____Has it occurred before? ☐Yes ☐No

Is the condition: (*please put an* **X** *where applicable, if none apply, please leave blank)*

☐Acute ☐Chronic ☐Gradual/Insidious

What Aggravates your condition? (*please put an* **X** *where applicable, if none apply, please leave blank)*

☐Sitting ☐Standing ☐Bending ☐Lifting ☐Lying Down ☐Other _____*(Indicate what)*

What relieves your condition? (*please put an* **X** *where applicable, if none apply, please leave blank)*

☐Ice ☐Heat ☐Bed Rest ☐Massage ☐Medication ☐Other_____*(Indicate What)*

Is it getting? (*please put an* **X** *where applicable, if none apply, please leave blank)*

☐Worse ☐Better ☐Comes/Goes ☐Constant

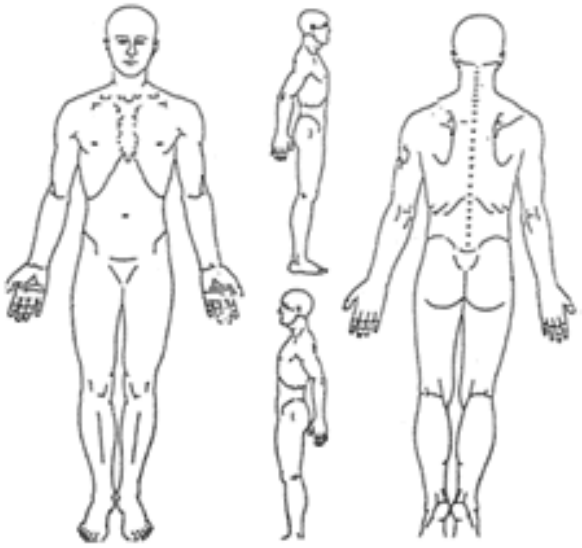
How would you describe it? (*please put an* **X** *where applicable, if none apply, please leave blank)*

☐Sharp ☐Dull ☐Ache ☐Pins/Needles ☐Numb ☐Burning ☐Constant ☐Intermittent

☐Other_____*(Indicate what)*

Show Area(s) of pain or unusual sensations/feeling:

Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation, include all affected areas.



Numbness	**Pins/Needles**	**Shooting**	**Aching**	**Stabbing**
oooooooo	ppppppppp	xxxxxxxxx	///////////	+++++++

Does this condition interfere with your ability to:

☐Work ☐Enjoy family/social time

☐Enjoy hobbies/sports

What is your pain right now?

No Pain ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ Worst Pain Imaginable

0 1 2 3 4 5 6 7 8 9 10

*Patient Name*_____*DOB*_____

*Practitioner Name*_____*Date*_____

Medications: (*please list* **ALL** *medications you are currently taking and the condition(s) they treat*

Major surgeries/injuries/medical condition(s) *(please list surgery/injury/condition + date occurred/started)*

Do you suffer from a **blood pressure ailment** (high or low blood pressure)? □Yes □No
Is it being controlled by medication? □Yes □No

Do you have any **allergies**? *(please list)*

Are you on allergy medication? □Yes □No

Health History

Please put an ***X*** *beside* ***ANY*** *symptoms you are experiencing* ***NOW*** *or have experienced in the* ***PAST****, even if they do not seem related to your current condition /complaint.*

General
1. ☐ Fever
2. ☐ Chills
3. ☐ Night Sweats
4. ☐ Loss of Sleep
5. ☐ Fatigue
6. ☐ Nervousness
7. ☐ Weight Loss or Gain
8. ☐ Bleeding Problems
9. ☐ Anemia
10. ☐ Diabetes
11. ☐ Cancer
12. ☐ Thyroid Disease/Goiter
13. ☐ Alcoholism
14. ☐ Drug Abuse

Eye, Ear, Nose, Throat
15. ☐ Poor Vision
16. ☐ Pain in Eye(s)
17. ☐ Deafness/Difficulty Hearing
18. ☐ Nosebleeds
19. ☐ Nose Problems
20. ☐ Sinus Trouble
21. ☐ Dental Problems
22. ☐ Hoarseness
23. ☐ Tonsillectomy

Gastrointestinal
24. ☐ Poor Appetite/Digestion
25. ☐ Difficulty Swallowing
26. ☐ Belching or Gas
27. ☐ Frequent Nausea
28. ☐ Vomiting
29. ☐ Vomiting Blood
30. ☐ Pain over Abdomen
31. ☐ Ulcer
32. ☐ Black or Bloody Stools
33. ☐ Liver Problems
34. ☐ Gall Bladder Problems
35. ☐ Jaundice
36. ☐ Hernia
37. ☐ Diarrhea
38. ☐ Constipation
39. ☐ Hemorrhoids
40. ☐ Appendicitis

Men Only
41. ☐ Testicular Swelling/Pain
42. ☐ Prostate Problems

Respiratory
43. ☐ Difficulty Breathing
44. ☐ Chronic Cough
45. ☐ Spitting Phlegm
46. ☐ Spitting Blood
47. ☐ Wheezing/Asthma
48. ☐ Pneumonia
49. ☐ Tuberculosis

Cardiovascular
50. ☐ Irregular Heartbeat
51. ☐ Pain over Heart
52. ☐ Previous Heart Trouble
53. ☐ Ankle Swelling
54. ☐ Varicose Veins
55. ☐ Rheumatic Fever
56. ☐ Stroke

Genitourinary
57. ☐ Frequent Urination
58. ☐ Painful Urination
59. ☐ Blood in Urine
60. ☐ Kidney Disease
61. ☐ Urinary Infection
62. ☐ Inability to Control Urination
63. ☐ Difficulty Starting Urine Flow
64. ☐ Get Up_____Times per Night to Urinate
65. ☐ Breast Lump or Pain
66. ☐ Venereal Infection
67. ☐ Sexual Difficulties

Skin
68. ☐ Itching
69. ☐ Bruising Easily
70. ☐ Change in mole(s)
71. ☐ Skin Cancer
72. ☐ List any other Skin Condition(s)
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Women Only
73. ☐ Painful Periods
74. ☐ Excessive Flow
75. ☐ Irregular Cycles
76. ☐ Vaginal Burning/Itching
77. ☐ Hot Flashes
78. ☐ Date Last Period Began_____
79. ☐ Date of Last Pap_____

Neurologic
80. ☐ Weakness
81. ☐ Twitching
82. ☐ Tremors
83. ☐ Headaches
84. ☐ Fainting
85. ☐ Dizziness
86. ☐ Convulsions
87. ☐ Epilepsy
88. ☐ Numbness/Tingling
89. ☐ Arm/Leg Pain
90. ☐ Mental/Mood Disorder

Musculoskeletal
91. ☐ Neck Stiffness/Pain
92. ☐ Pain Between Shoulders
93. ☐ Low Back Pain
94. ☐ Swollen/Painful Joints
95. ☐ Muscle Aches/Weakness
96. ☐ Spinal Curvature
97. ☐ Arthritis

Habits
98. ☐ Smoking,_____per day/week
99. ☐ Drinking,_____per day/Week
100. ☐ Recreational Drug Use
101. ☐ Exercise,_____times a week

Family History

Include information on brothers, sisters, parents and grandparents, ***DO NOT*** *include yourself.*

102. ☐ Diabetes
103. ☐ Cancer
104. ☐ Tuberculosis
105. ☐ Thyroid Disease/Goiter
106. ☐ Muscle, Nerve or Bone Disease
107. ☐ Kidney Disease
108. ☐ High Blood Pressure
109. ☐ Heart Disease

*Patient Name*_____*DOB*_____

*Practitioner Name*_____*Date*_____