

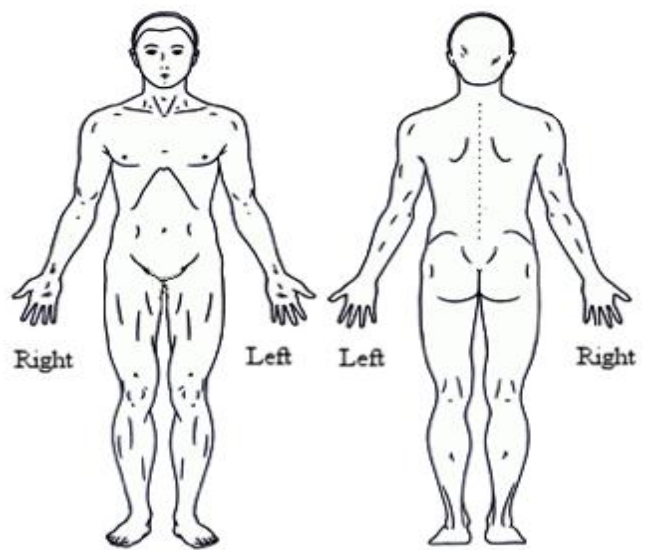
# Middlesex Spine & Sport Clinic - Confidential Patient Information/Case History

**Patient Information:**  
 Name \_\_\_\_\_  
 Address & PO Box \_\_\_\_\_  
 City \_\_\_\_\_ Postal Code \_\_\_\_\_  
 D.O.B (yyyy/mm/dd) \_\_\_\_\_ Age \_\_\_\_\_ Sex M / F  
 Home Telephone # \_\_\_\_\_  
 Work # \_\_\_\_\_  
 Cell # \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_  
 Phone # \_\_\_\_\_  
 How did you hear about this office? \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_  
 \_\_\_\_\_

**Previous Health Care:**  
 Have you had previous physiotherapy care? Yes / No  
 Provider's Name \_\_\_\_\_  
 When/Why? \_\_\_\_\_  
 Medical Doctor:  
 Name \_\_\_\_\_  
 Address/ Phone # \_\_\_\_\_  
 Date of last physical exam: \_\_\_\_\_  
 Did your medical doctor recommend that you seek physiotherapy? Yes / No  
 Is it ok if we communicate with your medical doctor regarding your health condition? Yes / No  
 Have you recently had x-rays or imaging? Yes / No  
 Date & Location: \_\_\_\_\_

**Chief Complaint:**  
 Primary Complaint \_\_\_\_\_  
 \_\_\_\_\_  
 Other Complaints \_\_\_\_\_  
 \_\_\_\_\_

Is this condition due to a motor vehicle accident? Y / N  
 Is this condition due to a work related accident? Y / N  
 Please mark all problem areas appropriately:



Sharp /// Burning XXX Dull Ache OOO  
 Pins/Needles +++ Numbness ●●●

Please circle the degree of pain (0=None, 10=Extreme)  
 0 1 2 3 4 5 6 7 8 9 10

Did the problem come on:  Suddenly  Slowly  
 When (date) did this problem begin? \_\_\_\_\_  
 How did this problem begin (mechanism)? \_\_\_\_\_  
 \_\_\_\_\_

Have you had a similar condition before? Yes / No  
 If yes, when? \_\_\_\_\_  
 Is the pain:  Improving  Unchanging  Worsening  
 Is the pain:  Constant  Intermittent  
 When does it bother you most? \_\_\_\_\_

What makes this condition better? \_\_\_\_\_

What makes this condition worse? \_\_\_\_\_

Does the pain radiate anywhere? If so, where? \_\_\_\_\_

What treatments, medications, etc have you tried using for this condition? Did they work? \_\_\_\_\_  
 \_\_\_\_\_

Does this condition interfere with:  Sleep  Work  
 Home life  Daily Routine  Recreation/exercise  
 Is there anything else that you think is relevant or important regarding your condition? \_\_\_\_\_  
 \_\_\_\_\_

Today's Date \_\_\_\_\_

# Middlesex Spine & Sport Clinic - Patient Health History

Please list any previous major illness, injuries, falls, motor vehicle accidents, hospitalizations or surgeries: _____ _____ _____ Please list any medications that you are currently taking or have taken recently _____ _____ _____	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border-bottom: 1px solid black;"><b>Social History/Habits</b></td> <td style="text-align: center;">None</td> <td style="text-align: center;">Light</td> <td style="text-align: center;">Moderate</td> <td style="text-align: center;">Heavy</td> </tr> <tr> <td>Alcohol</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Caffeine</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Sleep</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Exercise</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Tobacco</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td colspan="5">...If yes, how long have you smoked for? _____</td> </tr> <tr> <td colspan="5"><b>Work Activities</b></td> </tr> <tr> <td>Standing</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Sitting</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Lifting</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>	<b>Social History/Habits</b>	None	Light	Moderate	Heavy	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	...If yes, how long have you smoked for? _____					<b>Work Activities</b>					Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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**Health History** - Check off any of the following that **you** currently have or have had in the past (indicate age diagnosed):

<p><b>General</b></p> <input type="checkbox"/> Allergies <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Headaches <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Mental illness <input type="checkbox"/> Nervousness <input type="checkbox"/> Tremors <input type="checkbox"/> Vision problems <input type="checkbox"/> Weight loss/gain  <p><b>Muscle/ Joint</b></p> <input type="checkbox"/> Arthritis <input type="checkbox"/> Weakness <input type="checkbox"/> Back pain <input type="checkbox"/> Neck pain <input type="checkbox"/> Other joint pain: _____ _____	<p><b>Skin</b></p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Dryness <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Varicose veins  <p><b>Eye/Ear/Nose/Throat</b></p> <input type="checkbox"/> Colds <input type="checkbox"/> Deafness <input type="checkbox"/> Ear ache <input type="checkbox"/> Eye pain <input type="checkbox"/> Gum trouble <input type="checkbox"/> Hoarseness <input type="checkbox"/> Nasal obstruction <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Ringing of the ears <input type="checkbox"/> Sinus infection <input type="checkbox"/> Sore throat  <p><b>Cardiovascular</b></p> <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Atherosclerosis <input type="checkbox"/> Chest pain <input type="checkbox"/> Heart palpitation <input type="checkbox"/> Poor circulation	<p><b>Gastrointestinal</b></p> <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Bloody or tarry stool <input type="checkbox"/> Colitis/ Crohn's disease <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Digestion problems <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Bloating <input type="checkbox"/> Gallbladder problems <input type="checkbox"/> Hernia <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Intestinal worms <input type="checkbox"/> Liver disease <input type="checkbox"/> Nausea <input type="checkbox"/> Painful defecation <input type="checkbox"/> Vomiting of blood  <p><b>Genitourinary</b></p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Kidney stones <input type="checkbox"/> Prostate problems <input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Painful urination <input type="checkbox"/> Urgency to urinate	<p><b>Respiratory</b></p> <input type="checkbox"/> Chronic cough <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Spitting up phlegm/blood <input type="checkbox"/> Wheezing  <p><b>Women Only</b></p> <input type="checkbox"/> Breast disease <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Menopause Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many weeks: _____ Number of children: _____ Date of last pap test: _____ <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal  <p><b>Men Only</b></p> Have you ever had a prostate exam? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last exam: _____
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**Health History** - Please check any conditions that you have or have had and indicate the age at which you were diagnosed:

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Anemia	<input type="checkbox"/> Appendicitis	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Edema	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Goiter	<input type="checkbox"/> Gout	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Heart disease
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Pace maker	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Neurological Disorders	<input type="checkbox"/> Other

**Family History** – If any **blood relative** has had any of the following conditions, please check and indicate which relative:

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Autoimmune Disease	<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Cancer	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Disease

Is there anything else that has not been asked that you think is relevant or important in regards to your condition?

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What are your objectives in seeking Physiotherapy? (Please check all that apply)

<input type="checkbox"/> Relief of symptoms
<input type="checkbox"/> Improve spinal stability
<input type="checkbox"/> Improve range of motion/ mobility
<input type="checkbox"/> Decrease the risk of symptoms returning
<input type="checkbox"/> Improve nerve function
<input type="checkbox"/> Improve posture
<input type="checkbox"/> Decrease the risk of re-injury
<input type="checkbox"/> Increase energy level
<input type="checkbox"/> Decrease the risk of arthritis
<input type="checkbox"/> Increase athletic performance
<input type="checkbox"/> Relieve stress
<input type="checkbox"/> Improve overall health and well being
Other (Please list): _____

Patient understands potential benefits and risks of physiotherapy and consent to treatment. Patient agrees and understands that they are responsible for all charges related to their visit.

Name (please print): \_\_\_\_\_

Date: \_\_\_\_\_

Patient Signature/ Legal Guardian: \_\_\_\_\_