Physio4U Move More. Do More.
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Health Questionnaire (Form HQ)

Name (printed): _____ Email Address: _____

Mailing Address: _____ MB Health # (6 digit):_____

Date of Birth: ___/___/____ Doctor:_____ Occupation: _____

Phone Number: (____) ____-_____ Did your injury take place at work? _____ If Yes, are you off work? _____

Date of Onset of Symptoms: _____ Please rate your general health: Poor Fair Good Excellent

Have you had any recent hospital admissions (includes day surgery) (past 6 months)? _____.
If Yes, for what? _____

Have you had recent lab testing, x-rays or scan relating to your present problem? _____ If yes, what test did you have?
_____

Are you taking any medications? _____ If yes, what? _____

_____

Please check off (√) if you have been diagnosed with, or are experiencing any of the following:

__ HIV/Hepatitis (A,B or C)
__ Diagnosed Cancer (past/present) Type: _____
__ Prolonged indigestion
__ Night sweats
__ Unexplained weight loss
__ Constant night pain
__ Heart condition
__ Chest pain/shortness of breath
__ Cortisone injections or past/present treatment with steroidal medication such as Prednisone
__ Family history of arthritis (osteoporosis, rheumatoid arthritis or ankylosing spondylitis)
__ Other: _____
__ Smoking (past or present
__ Thyroid Problems
__ Memory or concentration difficulties
__ Allergies (_____)
__ Diabetes – Type: _____
__ Pacemaker
__ Pregnant (if yes, how many weeks? _____)
__ Rheumatic fever, polio or tuberculosis
__ Dizziness, blackouts, double vision, or frequent nausea
__ History of heart, stomach, urinary problems or epilepsy

PLEASE READ CAREFULLY (Please initial in space provided next to the 3 statements)

1. I understand that it may be necessary for the therapist and/or the Clinic to communicate and consult with my physician, case manager and/or adjuster in order to facilitate safe and appropriate intervention. I understand I have the right to refuse any part of assessment and treatment I am uncomfortable with, and will inform the therapist of any concerns I have. _____

2. 24 hour notice is required for all cancellations and changes in appointments. Failure to do so will result in a missed appointment fee. I have reviewed and understand this cancellation policy. _____

3. Email communication may be required to send your assessment forms/appointment reminders, personalized exercise programs or related videos. Due to Canada's Anti-Spam Law (CASL), unless you provide consent, we may not be able to reach out to you via email. Please initial if you consent to receiving emails from our clinic.
_____

_____ _____
Signature (Patient/Parent/Guardian) Date