PHYSIOACTIVE ORTHOPAEDIC & SPORTS INJURY CENTRE INC.

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information. Privacy Policy available upon request. Health Information Custodian (HIC): Thomas Hein

physioactive movement for life | ORTHOPAEDIC & SPORTS INJURY CENTRE

CLIENT PROFILE FORM – PLEASE COMPLETE
PLEASE BRING A COPY OF ANY RELEVANT TEST REPORTS IF AVAILABLE

NAME: ____ DATE OF BIRTH: _________________________

ADDRESS: ____ CITY:_______________ POSTAL CODE:__________

HOME PHONE:__________________ CELL PHONE:__________________ BUSINESS PHONE:__________________

FAMILY DR. ______________________________SPECIALIST MD FOR THIS ISSUE? ___________________________

EMAIL ADDRESS:________________________ OCCUPATION__________________ ________________________
Is it ok for us to email you appointment reminders, invoices or other Physioactive related emails? Yes?_________

WORK RELATED INJURY? ☐ Yes ☐ No MOTOR VEHICLE ACCIDENT? ☐ Yes ☐ No

MEDICAL INFORMATION (Please answer to the best of your knowledge):

Are you **pregnant** or trying to become pregnant?	☐ Yes	☐ No
Do you have any **prosthetic joints** (e.g. total knee or hip replacements)	☐ Yes	☐ No
Do you have **heart problems** and/or a pacemaker?	☐ Yes	☐ No
Do you have any **thyroid problems**?	☐ Yes	☐ No
Do you suffer from **headaches/migraines**?	☐ Yes	☐ No
Do you have any **lung conditions** (e.g. Asthma, COPD)	☐ Yes	☐ No
Do you have **diabetes**?	☐ Yes	☐ No
Do you suffer from **epilepsy**?	☐ Yes	☐ No
Do you have **osteoarthritis** in any joints?	☐ Yes	☐ No
Do you have an **inflammatory disease** (e.g. RA, Lupus, Ankylosing Spondylitis etc)?	☐ Yes	☐ No
Do you have a **bone loss** disease (e.g. Osteoporosis/Osteopenia, Pagets)?	☐ Yes	☐ No
Have you recently sustained a severe trauma involving **fracture** or **dislocation**?	☐ Yes	☐ No
Do you have a medical history involving **cancer**?	☐ Yes	☐ No
Have you noted any unplanned/unexplained **weight loss** recently?	☐ Yes	☐ No
Are you using **steroids** (e.g. Prednisone)	☐ Yes	☐ No
Do you have **blood disorders** (e.g. hemophilia) or on anticoagulants (e.g. Coumadin, Warfarin)?	☐ Yes	☐ No
Are you suffering from uncontrolled **high blood pressure**?	☐ Yes	☐ No
Do you have a **connective tissue disease** (e.g. Ehlers Danlos Syndrome, Marfan's syndrome)	☐ Yes	☐ No

OTHER CONDITIONS____

CURRENT MEDICATIONS____

HOW DID YOU HEAR ABOUT OUR CLINIC?

☐Doctor referral Who?__________ ☐Family/friend Who?___________ ☐Internet search ☐Close to home/work
☐Other:________________________

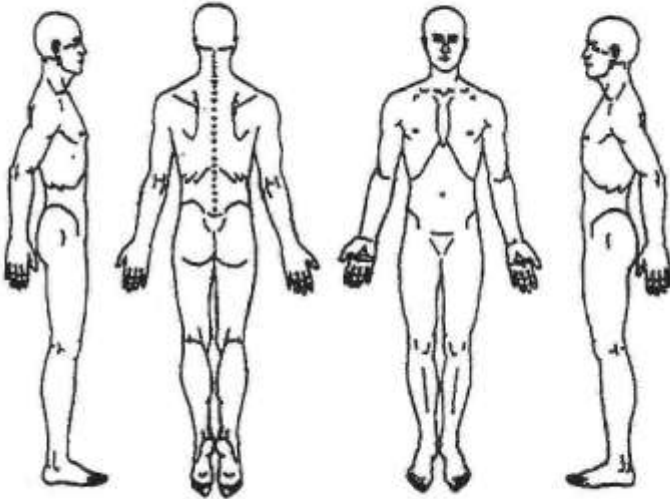
PLEASE DESCRIBE THE PROBLEMS THAT YOU ARE SEEKING TREATMENT FOR

WHAT ARE YOUR MAIN COMPLAINTS?

____

____

WHERE? USE THE BODY CHART TO SHADE IN YOUR PAIN OR OTHER SYMPTOMS – BE AS SPECIFIC AS YOU CAN



WHEN DID YOUR CURRENT PROBLEMS START?

____

____

____

ANY SPECIFIC INCIDENT THAT CAUSED YOUR PROBLEM?

____

____

____

WHAT MAKES YOU FEEL BETTER?

☐Sitting ☐Standing ☐Walking/Moving ☐Other:____________________________________

WHAT MAKES YOU FEEL WORSE?

☐ Sitting ☐Standing ☐Exercise ☐Rest ☐Medication ☐Other___________________________

HOW WOULD YOU DESCRIBE YOUR PAIN? (check all that apply)

☐Achy ☐Throbbing ☐Sharp ☐Burning ☐Other:_______________ ☐On & off OR ☐Constant

☐Getting better OR ☐Getting worse OR ☐Staying the same

☐Worse in the morning OR ☐Worse at night OR ☐No different

ANY INVESTIGATIONS? (e.g., X-RAY, CT scan, MRI) ____

HAVE YOUR HAD ANY OTHER INJURIES, TRAUMA OR SURGERIES?

Year:_____________ Injury:____

Year:_____________ Injury:____

Patient name:____Date completed: ____________________

ARE YOU EXPERIENCING ANY OF THESE SYMPTOMS?

☐Dizziness/blurred vision Comments:____

☐Balance problems Comments:____

☐Change in bladder or bowel function Comments:____

☐Numbness in the face Comments:____

☐Numbness in the groin region Comments:____

☐Pain with coughing or sneezing Comments:____

☐Difficulty swallowing Comments:____

PLEASE RATE YOUR PAIN **TODAY** BY CIRCLING THE APPROPRIATE NUMBER:

0 1 2 3 4 5 6 7 8 9 10

No pain Moderate pain Worst possible pain

Patient-specific activity scoring (daily activities, work activities, sports/leisure)

PLEASE IDENTIFY SOME **IMPORTANT ACTIVITIES OR TASKS** THAT YOU ARE **HAVING DIFFICULTY WITH, OR UNABLE TO DO** AS A RESULT OF YOUR PROBLEM:

Name of Activity	Unable to perform activity										Able to perform as well as before injury or problem
______________________	0	1	2	3	4	5	6	7	8	9	10
______________________	0	1	2	3	4	5	6	7	8	9	10
______________________	0	1	2	3	4	5	6	7	8	9	10

Patient name:____Date completed:_____________________

For permission to use our personalized digital video home exercise prescription software I, ________________________________, give consent to PHYSIOTEC via the intervention of a therapist, to use the PHYSIOTEC software in order to prescribe the care and services required my state of health, all for my benefit and according to how it was presented to me.I give Physioactive Orthopaedic & Sports Injury Centre, by a therapist, the authorization to transmit the information necessary for the prescription of health care services required for my state of health, in the utmost of confidentiality and in respect of all applicable laws, on the web server associated with the use of PHYSIOTEC software, property of Rapidenet Canada located 105 Beausejour, suite 202, Laprairie (Qc) J5R 5T6, Canada. This consent ceases to take effect when a prescription of services from my therapist required by my state of health is terminated. In otherwords I need permission from you to send you your home exercises over the internet. Sign if that is ok.

Signature: Date: