# 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? _Yyes?_____

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:_____



1577 Danforth Ave, Unit 4, Toronto M4C 1H7 | Tel: 416-691-3943 | Fax: 416-691-4755 |
www.mytorontophysio.com

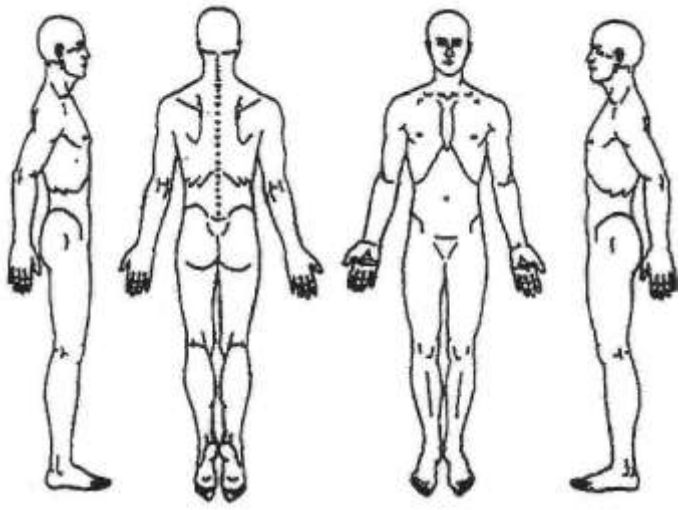
## PLEASE DESCRIBE THE PROBLEMS THAT YOU ARE SEEKING TREATMENT FOR

**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 ☐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:

| | Unable to perform activity | | | | | | | | | Able to perform as well as before injury or problem |
|---|---|---|---|---|---|---|---|---|---|---|
| **Name of Activity** | | | | | | | | | | |
| _____ | 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:_____



1577 Danforth Ave, Unit 4, Toronto M4C 1H7 | Tel: 905.695.0371 | Fax: 905.695.0263 |
www.**physioactive.ca**