

Pro Motion Physiotherapy Health Questionnaire

Patient Name: _____ Date: _____

Please complete this form to ensure optimum care. Information will remain confidential and be part of your physiotherapy chart.

Please notify us of any change in your medical condition.

1. Do you have a history of heart disease or chest pain?	Y	N
2. Do you often feel faint or have spells of severe dizziness?	Y	N
3. Do you have hypertension (high blood pressure)?	Y	N
4. Do you have diabetes?	Y	N
5. Do you have a pacemaker?	Y	N
6. Do you have osteopenia or osteoporosis?	Y	N
7. Do you have epilepsy/ seizures?	Y	N
8. Do you have asthma or other respiratory conditions?	Y	N
9. Do you have any allergies/ sensitivities to tape, creams, cold? If so please list:	Y	N
10. Are you pregnant?	Y	N
11. Do you smoke?	Y	N
12. Have you ever had or do you presently have cancer? If so please list:	Y	N
13. Have you ever had major surgeries or serious illnesses? If so please list:	Y	N
14. Are you taking any medications? If so please list:	Y	N
15. Do you have any bleeding disorders?	Y	N
16. Do you have any metal in your body? (e.g. joint replacement, pins, plates, screws, I.U.D., hearing aid, etc).	Y	N
17. Have you had any recent X-rays or scans during the past year?	Y	N
18. Are you receiving any other treatment at present? (e.g. chiropractic, massage, physiotherapy, osteopathy, etc). If so please list:	Y	N
19. Have you had physiotherapy previously? If so please list when and the reason:	Y	N
20. Is there any known medical reason that you are unable to participate in an exercise program at present?	Y	N
21. Is there anything else about your health that we should be aware of? If so please list:	Y	N

Emergency Contact

Name: _____ Phone: (_____) _____

Relationship to you: _____