

HAWKESBURY THERAPY

Date: ____/____/20____

Patient Name _____

Present Symptoms / what is your major complaint? _____

When did you first notice your major complaint? _____

What brought it on? _____

What activities aggravate condition? _____

Is this condition interfering with your work? ____ Yes ____ No ____ Constant ____ Comes and goes

What have you done to get relief? _____

Has there been a medical diagnosis? ____ Yes ____ No / Drs. Diagnosis _____

Related History:

Have you ever had this problem before? ____ Yes ____ No - If yes, when? _____

What caused those episodes? _____

What relieved them? _____

Did they disable you? ____ Yes ____ No Did they prevent you from working? ____ Yes ____ No Hospitalize you? ____ Yes ____ No

What was the previous diagnosis? _____ What were the treatments? _____

Did they help? ____ Yes ____ No

Are you on any medications? ____ Yes ____ No If yes, list them: _____

Allergies:

Food:.....Y	N	Iodine:.....Y	N
Penicillin:.....Y	N	Codeine:.....Y	N
Antibiotics :.....Y	N	Latex:.....Y	N
Aspirin:.....Y	N	Other:.....Y	N

Exams & treatments done for present condition:

Radiology (X-Rays)Y	N	Have you ever had surgery?.....Y	N
SCANY	N	Is so, describe:_____	
MRIY	N	Have you ever broken any bones?.....Y	N
EMG.....Y	N	If so, describe:_____	
Scintigraphy.....Y	N	Have you ever been in an accident?.....Y	N
Acupuncture.....Y	N	If so, describe:_____	
Chiropractor.....Y	N	Have you ever received a whiplash?.....Y	N
Osteopathy.....Y	N	Are you pregnant?.....Y	N
Massage therapy.....Y	N	Are you wearing an intra uterine device?.....Y	N
Orthotherapy.....Y	N	Do you smoke?Y	N
Other: _____		Leisure activities: _____	
		Field of work: _____	

(Please circle all that apply) Do you have difficulty with any of the following:

Headaches	Liver problems	High blood pressure	Sexually transmitted infection
Migraines/ head aches	Kidney trouble	Low blood pressure	HIV/Aids
Indigestion	TB /Lung problems	Fatigue / Depression	Ringing in ears
Hay fever	Diabetes	Arthritis	Light sensitivity
Asthma	Thyroid trouble	Anaemia	Nervousness
Frequent colds	Wear pacemaker	Urinary problems	Eye problems (glaucoma etc.)
Constipation /Diarrhea	Heart valve problems	Artificial joints(hip, knee)	Skin condition
Nausea/ vomiting	Heart palpitation /chest pains	Hearing aid	Cancer
Abdominal pain	Heart murmur	Dizziness	Memory loss
Flatulence /Bloating	Heart attacks	Fainting / Dizziness	Shortness of breath
Black or red stool	Angina	Stomach ulcers	Prolonged bleeding
Haemorrhoids	Joint pain	Epilepsy	Other (please explain)
Chest wheezing	Swollen joints	Loss of balance	_____

HAWKESBURYTHERAPY

Statement of Acknowledgment

I the undersigned declare to have read, understood, informed myself and have answered the questionnaire to the best of my knowledge. I hereby promise to advise you of any change in my state of health. I authorize the constitution of my chart. I understand that my file will be kept at the clinic at all times and that the physiotherapist(s) and his (their) support personnel will have access to it. I also know my right to consult my chart and to request rectifications if need be.

Patient signature: _____

Cancellation policy

In order to be respectful of our patient's needs, please be courteous and call the reception promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. This is how we can best serve the needs of our patients. If it is necessary to cancel your scheduled appointment we require that you call one working day in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely care. There will be a \$20 charge if you fail to show up for a scheduled appointment or cancel with less than 24 hours notice.