Cooper Physiotherapy

Name: _____ DOB: (Y/M/D) _____

How Did You Hear About The Clinic? _____

Emergency Contact: _____ Phone Number: _____

Relationship to You: _____

What Is the Main Reason You Are Seeking Therapy Today? Please Include Location(s) of Tissue/Joint Discomfort:

_____

Health History - Please Check (√) All That Apply To You:

General:

__ Headaches
Type: _____
__ Vision problems
__ Sinus
__ Allergies: _____
__ Chronic Pain: _____
__ Chronic Fatigue
__ Dizziness
__ Premenstrual Syndrome (PMS)
__ Menopause
__ Pregnancy: # of Weeks: _____

Skin:

__ Sensitive Skin
__ Rashes or Sores
__ Warts
__ Varicose Veins
Location: _____
__ Eczema
__ Psoriasis

Cardiovascular:

__ High Blood Pressure
Medicated? : Yes __ No __
__ Low Blood Pressure
Medicated? : Yes __ No __
__ Poor Circulation
__ Heart Disease
__ Phlebitis

Respiratory:

__ Chronic Cough
__ Chronic Colds
__ Shortness of Breath
__ Smoker: # Per Day _____
__ Asthma

Digestive/Uro-Genital:

__ Hernia
__ Poor Appetite
__ Constipation
__ Liver/Gallbladder
__ Kidney/Bladder
__ Digestive Problems

Muscle & Joints:

__ Stiffness
__ Swelling
__ Limited Movement
__ Back Pain
__ Shoulder Pain
__ Neck Pain
__ Pain in Limbs
__ Pins & Needles
__ Rheumatoid Arthritis
__ Osteoarthritis

Other:

__ Hepatitis/HIV/AIDS
__ Diabetes: Medicated?
Yes__ No __
__ Epilepsy: Medicated?
Yes__ No __
__ Immune Disorder
__ Cancer
__ Depression/Grief
__ Other: Please Describe:
_____
_____
_____

Surgeries/Injuries/Metal Plates or Pins?

_____
_____
_____

Current Medications and What They Treat:

_____
_____
_____

Are You Being Treated By Any Other Health Care Providers: _____

Are You Being Followed By Any Specialists? _____

I understand that the information that I give on this form will be confidential and will be used for no other purpose than the therapists' clinical records. I acknowledge that all the information recorded on this form is accurate and complete.

Date: _____ **Signature: _____**