

Cooper Physiotherapy
Confidential Health History Form

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 (v) 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: _____