PHYSICAL THERAPY MEDICAL HISTORY FORM

Name: ____ **Date of Birth:**_____/_____/_____
First Middle Surname Year Month Day

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Have you received assessment or treatment for this body part at another physio clinic since April 1st? Y N
2. Have you had surgery for this injury within the last 8 weeks? Y N
3. Have you had a cast removed from the injured body part within the last 2 weeks? Y N
4. Is this injury the result of a workplace accident (WCB)? Y N
5. Is this injury the result of a motor vehicle accident that has occurred in the last 90 days? Y N
6. Do you or your spouse have insurance benefits that include physical therapy? Y N

   If Yes, please print insurance company name: ______________________________________

HAVE YOU EVER, OR ARE CURRENTLY BEING TREATED FOR ANY OF THE FOLLOWING

- ❑ Seizures/Stroke
- ❑ Osteoporosis
- ❑ Cancer: Type ___________________
- ❑ Diabetes
- ❑ Do you have a Pacemaker?
- ❑ Bleeding problems
- ❑ Blood Clots
- ❑ Anemia
- ❑ Fainting or Dizziness
- ❑ Are you Pregnant?
- ❑ Depression
- ❑ Chest Pain/Angina
- ❑ High Blood Pressure
- ❑ HIV

HISTORY OF PRESENT INJURY

What part of your body is presently injured? ____

When were you injured? ____

ACKNOWLEDGEMENT / CONSENT

I understand my diagnosis and treatment plan will be discussed during my first appointment and that I have the right to question and/or refuse any treatment prior to it being applied. I therefore take all responsibility to ensure I understand the nature of the services. I acknowledge that no guarantees have been made to me as to the results of services. This consent is effective until such time as I withdraw my consent in writing.

Conditions of Services provided by Alberta Health Services (AHS) – I understand that should any portion of my assessment or treatment be funded under Alberta Health, any information collected during the assessment or treatment may be disclosed to AHS for purpose of payment for my physical therapy and/or review of the AHS program.

Your signature below indicates you understand and comply with the above statements.

Signature of Patient or Legal Guardian: ______________________________ Date: ____________________