# Health History

DALHOUSIE Physiotherapy Clinic

Name: ______________________________ D.O.B: ______________ (dd/mm/yyyy)

Gender: ☐ Male ☐ Female ☐ Non-Binary

## Current Complaints

Is this problem: ☐ chronic ☐ sudden onset ☐ Acute (recent injury or flair up)

When did the problem start? ____________________

Have your been to see another practitioner for this problem (PT, Chiro, Massage Therapy)? ☐ Yes
If yes please list them here: ______________________________________________

Briefly describe your present symptoms:

Pain? ☐ No ☐ yes – Where? ________________________________
Numbness or Tingling? ☐ No ☐ yes – Where? ________________________
Weakness? ☐ No ☐ yes – Where? ________________________________
Headaches? ☐ No ☐ yes
Is this problem: ☐ getting better ☐ getting worse ☐ staying the same
Does it affect your sleep? ☐ No ☐ yes

## Past Medical History

Do you have or have you ever had:

| | | |
|---|---|---|
| ☐ Diabetes | ☐ Heart murmur | ☐ Crohn's Disease/IBS |
| ☐ High blood pressure | ☐ Pneumonia | ☐ Colitis |
| ☐ High cholesterol | ☐ Pulmonary embolism or DVT | ☐ Anemia |
| ☐ Hypothyroidism | ☐ Asthma | ☐ Jaundice |
| ☐ Hyperthyroidism | ☐ Emphysema | ☐ Hepatitis |
| ☐ Cancer (type) ____________ | ☐ Stroke | ☐ Stomach or peptic ulcer |
| ☐ Leukemia | ☐ Epilepsy (seizures) | ☐ Rheumatic fever |
| ☐ Psoriasis | ☐ Cataracts | ☐ Tuberculosis |
| ☐ Angina | ☐ Kidney disease | ☐ HIV/AIDS |
| ☐ Heart problems | ☐ Kidney stones | ☐ Fibromyalgia |
| ☐ Balance problems | ☐ Rheumatoid arthritis | ☐ Osteoarthritis |
| ☐ MS | ☐ Breathing problems | ☐ Ligament sprain |
| ☐ Muscle strain | ☐ Broken bone (where) | ☐ Joint replacement |
| ☐ Pacemaker | ☐ Osteoporosis | |
| Other Medical Conditions: | | |

## Curent Medications

Do you have or have you ever had:

Drug allergies ☐ No ☐ yes – To what? ______________________________
Please list any medications that you are now taking. Include non-prescription medications & Vitamins or supplements:

| Drug Name | Dosage | How long have your been taking this |
|---|---|---|
| | | |

# Health History

| | | |
|---|---|---|
| | | |

## Systems Review

In the past month, have you had any of the following problems?

**GENERAL**
☐ Recent weight gain; how much____
☐ Recent weight loss: how much____
☐ Fatigue
☐ Weakness
☐ Fever
☐ Night sweats

**EARS**
☐ Ringing in ears
☐ Loss of hearing

**EYES**
☐ Pain
☐ Redness
☐ Loss of vision
☐ Double or blurred vision
☐ Dryness

**THROAT**
☐ Frequent sore throats
☐ Hoarseness
☐ Difficulty in swallowing
☐ Pain in jaw

**HEART AND LUNGS**
☐ Chest pain
☐ Palpitations
☐ Shortness of breath
☐ Fainting
☐ Swollen legs or feet
☐ Cough

**OTHER:**

**NERVOUS SYSTEM**
☐ Headaches
☐ Dizziness
☐ Fainting or loss of consciousness
☐ Numbness or tingling
☐ Memory loss

**STOMACH AND INTESTINES**
☐ Nausea
☐ Heartburn
☐ Stomach pain
☐ Vomiting
☐ Yellow jaundice
☐ Increasing constipation
☐ Persistent diarrhea
☐ Blood in stools
☐ Black stools

**SKIN**
☐ Redness
☐ Rash
☐ Nodules/bumps
☐ Hair loss
☐ Color changes of hands or feet

**BLOOD**
☐ Anemia
☐ Clots

**KIDNEY/URINE/BLADDER**
☐ Blood in urine
☐ Frequent or painful urination

**MUSCLE/JOINTS/BONES**
☐ Numbness
☐ Joint pain
☐ Muscle weakness
☐ Joint swelling Where?
_________________

**MENTAL HEALTH**
☐ Depression
☐ Excessive worries
☐ Difficulty falling asleep
☐ Difficulty staying asleep
☐ Anxiety
☐ Poor appetite
☐ Food cravings
☐ Frequent crying
☐ Sensitivity
☐ Thoughts of suicide / attempts
☐ Stress
☐ Irritability
☐ Poor concentration
☐ Racing thoughts
☐ Hallucinations
☐ Rapid speech
☐ Guilty thoughts
☐ Paranoia

**Women Only:**
☐ Abnormal Pap smear
☐ Irregular periods
☐ Bleeding between periods
☐ PMS

I understand that it is important that my health care practitioner is aware of any health-related issues I might have, and have completed this form to the best of my ability:

Patient Signature: ______________________________________

I have reviewed this patient's health history: Clinician: _____________________________________