

HELIOS REHABILITATION & PERFORMANCE

1605 Victoria Rd. W, Unit 5
Box 1998, Revelstoke, BC, V0E 2S0

phone: 250.837.7171
fax: 250.837.7161

email: clinic@heliosphysio.com
web: www.heliosphysio.com

Confidential Patient History Form

Name: _____ Birthdate: _____
 Address: _____ Care card #: _____
 _____ Family Doctor: _____
 _____ Referring Professional: _____
 Phone: (home): _____ Phone: _____
 (cell): _____
 (work): _____
 Email: _____
 Occupation: _____ Extended Medical Insurer: _____
 ICBC or WCB? (circle), Claim #: _____
 How did you hear about our clinic? _____

I authorize Helios Rehabilitation & Performance and its associated therapists to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated therapists to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Please note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow clients, we ask that you provide us with 24 hours notice of cancellation, otherwise a cancellation/no-show fee of \$25 will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the client.

Signature: _____ Date: _____

Name & signature of parent/guardian if client is under 18: _____

Medical History

Please indicate if you believe if any of the following apply to you. (P = past, C = current)

Please also indicate any medication you are taking for the conditions listed below.

Yes	No	<input type="checkbox"/> <input type="checkbox"/> High/Low Blood Pressure	<input type="checkbox"/> Altace (ramipril)	<input type="checkbox"/> Hydrochlorothiazide	<input type="checkbox"/> Metoprolol	<input type="checkbox"/> Adalat		
<input type="checkbox"/>	<input type="checkbox"/>	Heart Condition	_____					
<input type="checkbox"/>	<input type="checkbox"/>	Stroke or Aneurysm	_____					
<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Other Respiratory Condition	<input type="checkbox"/> Corticosteroids	<input type="checkbox"/> Ventolin				
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/> Insulin _____					
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Other Seizures	_____					
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/> Celebrex	<input type="checkbox"/> Arthrotec				
<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/> Fosamax _____					
<input type="checkbox"/>	<input type="checkbox"/>	Artherosclerosis	_____					
<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	_____					
<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/> Lipitor	<input type="checkbox"/> Crestor				
<input type="checkbox"/>	<input type="checkbox"/>	Major infection/cellulitis	<input type="checkbox"/> Gentamicin _____					

Yes	No	<input type="checkbox"/> <input type="checkbox"/> Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	HIV
<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease
<input type="checkbox"/>	<input type="checkbox"/>	Implants
<input type="checkbox"/>	<input type="checkbox"/>	Transplant
<input type="checkbox"/>	<input type="checkbox"/>	Corrective Lenses/Contacts
<input type="checkbox"/>	<input type="checkbox"/>	Depression/Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Allergies (please specify)

Confidential Patient History Form (page 2)

- | | | | | | |
|--------------------------|--------------------------|-----------------------------|--------------------------|--------------------------|---|
| Yes | No | | Yes | No | |
| <input type="checkbox"/> | <input type="checkbox"/> | Varicose Veins | <input type="checkbox"/> | <input type="checkbox"/> | Headaches / Migraines |
| <input type="checkbox"/> | <input type="checkbox"/> | Bruise Easily | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness / Fainting / Vertigo |
| <input type="checkbox"/> | <input type="checkbox"/> | Haemophilia | <input type="checkbox"/> | <input type="checkbox"/> | Nausea |
| <input type="checkbox"/> | <input type="checkbox"/> | Other Circulatory Condition | <input type="checkbox"/> | <input type="checkbox"/> | Changes in vision |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin Condition | <input type="checkbox"/> | <input type="checkbox"/> | Difficulty Swallowing |
| <input type="checkbox"/> | <input type="checkbox"/> | Currently pregnant | <input type="checkbox"/> | <input type="checkbox"/> | Speech Difficulty / Change |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Sinusitis | <input type="checkbox"/> | <input type="checkbox"/> | Change/loss of bowel/bladder |
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing Loss | <input type="checkbox"/> | <input type="checkbox"/> | Urinary Condition |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Irritable Bowel / Colitis / Other Digestive Condition |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | Other Neurological Condition |

Please list any other **prescription or non-prescription** medications (including herbal supplements, vitamins, etc...) you presently take. Please also indicate the frequency:

Do you have any family history of medical conditions? Yes No

Injury History

Please indicate if you have ever:	Yes	No	If yes, please indicate how many times and whether birth was natural or c-section:
Given birth?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you had any...			_____
Major falls?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide details for any boxes checked:
Motor vehicle accidents?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Concussions?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dislocations/bone fractures?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Major accidents or illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ligament sprains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle strains?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other muscle/bone/joint problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other surgeries?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hospitalized for any other reason?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other therapy / treatments: (past or present, does not have to be related to this visit)

	Area(s) treated	Past	Current
<input type="checkbox"/> Massage Therapy	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chiropractor	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physiotherapy	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Naturopath	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Acupuncture	_____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other _____	_____	<input type="checkbox"/>	<input type="checkbox"/>

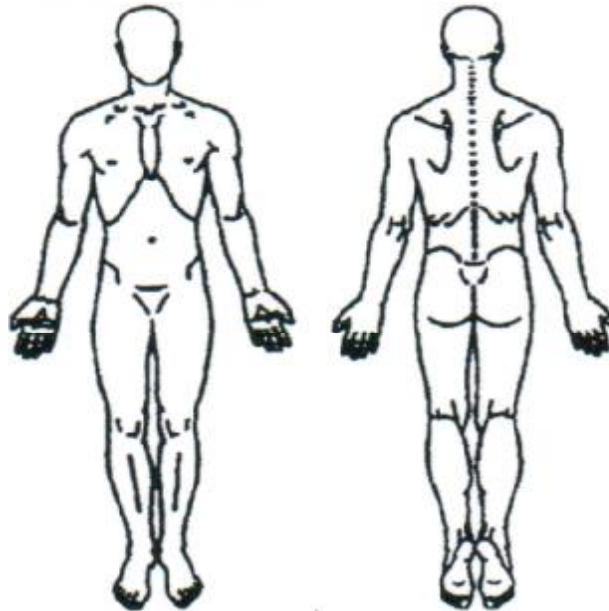
Confidential Patient History Form (page 3)

Current Condition

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:

How long have you had this condition?

How did it start?



- Aching ○ ○
- Stabbing X X X
- Shooting → →
- Burning # # #
- Numbness or Tingling ~ ~ ~

What aggravates it?

Do you wake from the pain? y / n Are you able to fall back to sleep? y / n How?

What relieves it? (circle) Movement - Change in position - Heat - Ice - Medication
 Topical Creams - Other: _____

Other notes:

Have you had any imaging/diagnostic tests done? ie: X-ray, CT scan, MRI, Ultrasound, Bloodwork

Please list any activities, sports, hobbies:

Please circle the answer closest to how you PRESENTLY feel : (1 = poor, 5 = excellent)

- Quality of Sleep 1 2 3 4 5
- Energy Level 1 2 3 4 5
- Eating Habits 1 2 3 4 5
- Stress Level 1 2 3 4 5
- Exercise Habits 1 2 3 4 5

Hours of sleep per night (approx.): _____

Preferred sleep position: _____

Number of meals you regularly eat per day: _____

Number of times you exercise per week: _____

Are you right or left-handed? _____