

Milestones Physical Therapy Services

Patient Information

Date: _____ Alberta Health Care Number: _____

First Name: _____ Surname: _____ Middle Initial: _____

Date of Birth (M/D/Y): _____ Age: _____ Sex: M F

Address: _____

City: _____ Province: _____ Postal Code: _____

Occupation: _____ Marital Status: _____ Children: _____

CONTACT INFORMATION

	Number	Extension
Home:	_____	_____
Phone (bus):	_____	_____
Phone (cell):	_____	_____
Fax:	_____	_____
Email Address:	_____	

REFERRAL INFORMATION

- | | |
|---|--|
| <input type="checkbox"/> Personal Referral: _____ | <input type="checkbox"/> Internet |
| <input type="checkbox"/> Doctor Referral: _____ | <input type="checkbox"/> Phone Book |
| <input type="checkbox"/> Physiotherapist: _____ | <input type="checkbox"/> Walk-In |
| <input type="checkbox"/> Massage Therapist: _____ | <input type="checkbox"/> Welcome Wagon |
| <input type="checkbox"/> Midwife / Doula: _____ | <input type="checkbox"/> Other _____ |

YOUR HEALTH CARE TEAM

Family Doctor: _____ Massage Therapist: _____
Naturopath: _____ OB/GYN: _____
Midwife/Doula: _____ Other Care Providers: _____

INSURANCE

Do you have Extended Health Coverage? Yes No
Insurance Company: _____

Motor Vehicle Accident (if applicable)		
Are you seeking treatment for a Motor Vehicle Accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of Motor Vehicle Accident:	_____	
Have you seen another practitioner in regards to this accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Type of practitioner:	<input type="checkbox"/> Physiotherapist	<input type="checkbox"/> Medical Doctor <input type="checkbox"/> Chiropractor
Name of Practitioner:	_____ Date of Assessment: _____	
Insurance Company:	_____ Phone Number: _____	
Name of Claim Worker:	_____ Claim #: _____	

CURRENT HEALTH CONDITION

Purpose of this Appointment: _____

Major Complaint: _____

Explain How Complaint Occurred: _____

When did this condition begin?: _____

Condition has persisted for: Days Weeks Months Years

Condition developed from: Auto Accident Work Injury Other Injury _____

Symptoms Came on suddenly Come & Go

What activities make this condition better? _____

What activities make this condition worse? _____

Symptoms are BETTER in: AM Midday PM

Symptoms are WORSE in: AM Midday PM Do not change with time of day

Have you ever had this condition before? No Yes, when _____

Other doctors seen for this condition: _____

Describe other complaints involving:

 Neck/Head: _____

 Mid-back/Shoulders/Arms: _____

 Low-back/Hips/Legs: _____

Medications/supplements/vitamins you are taking: _____

For what conditions: _____

Women: Are you pregnant? Yes No How many weeks? _____ Due Date: _____

INDICATE ABILITY TO PERFORM THE FOLLOWING ACTIVITIES:

U – Unable P – Painful D – Difficult L – Limited N – Normal

___ Coughing or Sneezing

___ Getting in or out of car

___ Turning over in bed

___ Walking short distances

___ Standing more than 1 hour

___ Sitting at table

___ Lying on back

___ Lying flat on stomach

___ Lying on side w/ Knees bent

___ Bending over forward

___ Climbing

___ Kneeling

___ Balancing

___ Dressing self

___ Sleeping

___ Stooping

___ Gripping

___ Pushing

___ Pulling

___ Reaching

___ Sexual Activity

___ Holding child

___ Carrying car seat

Other information: _____

I confirm that the information I have provided in regards to my current condition and past health history is true and complete to the best of my knowledge.

Signature: _____

Date: _____

PAST HEALTH HISTORY

CHECK ANY DISEASE / ILLNESS YOU HAVE HAD:

- | | | | |
|--|------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Measles | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Mumps | <input type="checkbox"/> Chrohns |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> A.I.D.S. | <input type="checkbox"/> Influenza | <input type="checkbox"/> Cancer _____ | |

CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE and UNDERLINE THOSE YOU HAVE HAD IN THE PAST:

MUSCULO-SKELETAL

- Low back pain
- Pain between shoulders
- Neck pain
- Arm pain
- Joint pain/Stiffness
- Walking problems
- difficult chewing/Clicking jaw
- General stiffness
- Other _____

NERVOUS SYSTEM

- Nervousness
- Numbness _____
- Dizziness
- Forgetfulness
- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling extremities
- Stress

GENERAL

- Fatigue
- Loss of sleep
- Headaches
- Fever
- Poor appetite
- Allergies _____

FAMILY HISTORY (for example, Cancer/ Diabetes/Heart Problems/Back or Neck Pain)

Father: _____
Mother: _____
Brothers: _____
Sisters: _____

CARDIO-VASCULAR

- Blood pressure problems
 - Heart problems
 - Lung problems/Congestion
 - Stroke
 - Chest pains
- ### RESPIRATORY
- Asthma
 - Difficulty Breathing

DIGESTIVE TRACT

- Nausea
- Heartburn
- Gas/Bloating after meals
- Constipation
- Diarrhea
- Bowel infections
- Weight issues

GENITO-URINARY

- Bladder issues
- Painful Urination
- Excessive urination
- Yeast infections

HABITS

- Caffeine: cups/day: _____
- Smoking: packs/day: _____
- Drinking: alcohol/wk: _____
- Fast Food: meals/wk: _____
- Junk Food: items/wk: _____
- Sleep: hours/night: _____
- Stress: low moderate high

MALE/FEMALE

- Menstrual Irregularity
- Menstrual cramping
- Vaginal pain/Infections
- Breast pain/Lumps
- Miscarriage
- Difficulty Conceiving
- Endometriosis/ovarian cysts

EYE/EAR/NOSE/THROAT

- Vision problems
- Hearing difficulty
- Ear aches

EXERCISE (check one)

- none moderate daily
- What? _____

DIET

- Poor
- Average
- Healthy (low fat, balanced meals)
- Organic
- Vegetarian

Have you had Physical Therapy treatment previously? Yes No

Location and reason _____

List all accident or falls: _____

Surgeries/ Operations: _____

Hospitalizations: _____

Milestones Physical Therapy Services

INFORMED CONSENT TO PHYSICAL THERAPY ASSESSMENT AND TREATMENT

The following is a list of modalities and procedures used in physical therapy. Your physical therapist will explain which ones will be used during your assessment and treatment, and will discuss treatment alternatives and goals of treatment with you.

Assessment (including, but not limited to, active and passive joint range of motion, strength testing, neurological testing, and/or special tests)

Massage and Muscle Release Techniques

Functional Training (body mechanics, Activities of Daily Living)

Joint Mobilization ***Muscle Stretching***

Heat ***Ice***

Traction ***Kinesiotape or other taping***

Electrical Stimulation ***Acupuncture***

Postural Training ***Therapeutic Exercise***

During your physical therapy it is often necessary to expose or touch the area to be treated. Every effort is made to preserve modesty and keep you comfortable. Your physical therapist will advise you of appropriate dress for your treatment sessions.

Consent For Treatment

I give my consent for assessment and treatment by the physical therapy staff of Milestones Physical Therapy Services and the Lifestyles Wellness Group. I understand that to evaluate and treat my condition, the physical therapy staff must have visual and/or physical access to the areas of my body which may be experiencing and/or causing my pain and or dysfunction. I understand that it is my responsibility to immediately communicate any difficulties or concerns that I have regarding my therapy to the staff of Lifestyles Wellness Group. I understand that as with any course of treatment or therapy, there is always the possibility of an unexpected complication and no guarantee has been made as to the results of treatment. I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my physical therapist the nature of my condition, the treatment options and recommendations for my condition, and the contents of this Consent.

Client (Legal Guardian) Name (please print): _____

Client (Legal Guardian) Signature: _____ Date _____

Therapist Name (please print): _____

Therapist Signature _____ Date _____
