PHYSIOTHERAPY HEALTH HISTORY FORM

An accurate health history is important to ensure that it is safe for you to receive treatments. If your health status changes, please let us know. All information collected is confidential, except as required or allowed by law or to facilitate diagnosis or treatment.

PERSONAL HISTORY

DATE: DD / MM / YYYY

FIRST NAME LAST NAME

ADDRESS | CITY | POSTAL CODE | DD / MM / YYYY DATE OF BIRTH

( ) HOME PHONE | ( ) MOBILE PHONE | EMAIL ADDRESS (For Appointment Reminders and quarterly newsletter)

EMPLOYER INFORMATION

EMPLOYER | OCCUPATION

ADDRESS | CITY | POSTAL CODE | ( ) WORK PHONE

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ Internet ☐ Phone Book ☐ Massage Therapist ☐ Friend / Family _____

☐ Brochure ☐ Medical Doctor ☐ Postcard Mailer ☐ Other _____

PREVIOUS PHYSIOTHERAPY ☐ YES ☐ NO

PHYSIOTHERAPISTS NAME | DD / MM / YYYY DATE OF LAST VISIT (APPROX.)

CLINIC NAME

X-rays ☐ **YES** ☐ **NO**

OTHER PRACTITIONERS SEEN

MASSAGE THERAPY	☐ **Y** ☐ **N**	**DATE** _____
CHIROPRACTOR	☐ **Y** ☐ **N**	**DATE** _____
OSTEOPATHY	☐ **Y** ☐ **N**	**DATE** _____
ACUPUNCTURE	☐ **Y** ☐ **N**	**DATE** _____
OTHER _____	☐ **Y** ☐ **N**	**DATE** _____

PRIMARY CARE MEDICAL DOCTOR

I authorize Target Therapeutics to send a report.

☐ **NO** ☐ **YES** **INITIAL** _____

DOCTORS NAME | CITY

DO YOU WEAR FOOT ORTHOTICS ☐ YES ☐ NO

HOW LONG HAVE YOU WORN THEM? _____

HOW LONG SINCE YOUR LAST PAIR? _____

PHYSIOTHERAPY HEALTH HISTORY FORM

PAST MEDICAL HISTORY

GENERAL

- ☐ Numbness/Tingling
- ☐ Loss of Sensation
- ☐ Vision Loss
- ☐ Blurred Vision
- ☐ Hearing Loss
- ☐ Earache
- ☐ Headache
- ☐ Cancer
- ☐ Fainting
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fever
- ☐ Sweats
- ☐ Balance Problems

MUSCLES & JOINTS

- ☐ Stiffness
- ☐ Weakness
- ☐ Arthritis
- ☐ Neck Pain
- ☐ Knee Pain
- ☐ Arm Pain
- ☐ Leg Pain
- ☐ Shoulder Pain
- ☐ Osteoporosis
- ☐ Upper Back Pain
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Swollen Joints
- ☐ Other _____

GASTROINESTINAL

- ☐ Indigestion
- ☐ Nausea
- ☐ Diarrhea
- ☐ Colitis
- ☐ Poor Appetite
- ☐ Excessive Gas
- ☐ Constipation
- ☐ Ulcers

CARDIOVASCULAR

- ☐ Heart Disease
- ☐ Poor Circulation
- ☐ Swelling in Ankles
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Attack
- ☐ Deep Vein Thrombosis
- ☐ Stroke/CVA
- ☐ Pacemaker
- ☐ Varicose Veins

INFECTIONS

- ☐ Hepatitis
- ☐ TB
- ☐ HIV
- ☐ Other _____

RESPIRATORY

- ☐ Chronic Cough
- ☐ Chest Pain
- ☐ Asthma
- ☐ Emphysema
- ☐ Chronic Bronchitis
- ☐ Sinus Problems
- ☐ Asthma
- ☐ COPD

- Please specify any other medical conditions you may have that are not listed: _____
- Presence of internal pins, wires, artificial joints, special equipment: _____
- Had an accident? ☐ **YES** ☐ **NO**
  If **YES**, please describe: _____
- Had an operation? ☐ **YES** ☐ **NO**
  If **YES**, please describe: _____
- Had a fracture? ☐ **YES** ☐ **NO**
  If **YES**, please describe: _____
- Been hospitalized? ☐ **YES** ☐ **NO**
  If **YES**, please describes: _____
- Have you had cancer? ☐ **YES** ☐ **NO**
  If **YES**, please describe: _____

MEDICATION / SUPPLEMENTS

- ☐ Anti-inflammatory
- ☐ Antibiotics
- ☐ Cholesterol
- ☐ Anti-anxiety
- ☐ Muscle Relaxants
- ☐ Antacids
- ☐ Blood Pressure
- ☐ Depression
- ☐ Pain Killers
- ☐ Blood Thinners
- ☐ Vitamins/Herbs
- ☐ Essential Fats
- ☐ Other: _____

STRESS LEVELS

- ☐ **LOW**
- ☐ **MODERATE**
- ☐ **HIGH**

PHYSIOTHERAPY HEALTH HISTORY FORM

CURRENT HEALTH CONDITION

Primary Complaint (Reason for coming in): _____

Has it occurred before: ☐ **NO** ☐ **YES** _____ How many times: _____

Is it: ☐ Job Related ☐ Car Related ☐ Home Related ☐ Stress Related ☐ Injury ☐ Other: _____

Is the pain getting: ☐ Worse ☐ Better ☐ Constant ☐ Comes and Goes ☐ Other: _____

What aggravates your condition?

☐ Sitting ☐ Lifting ☐ Heat
☐ Standing ☐ Lying ☐ Cold
☐ Bending ☐ Walking ☐ Other: _____

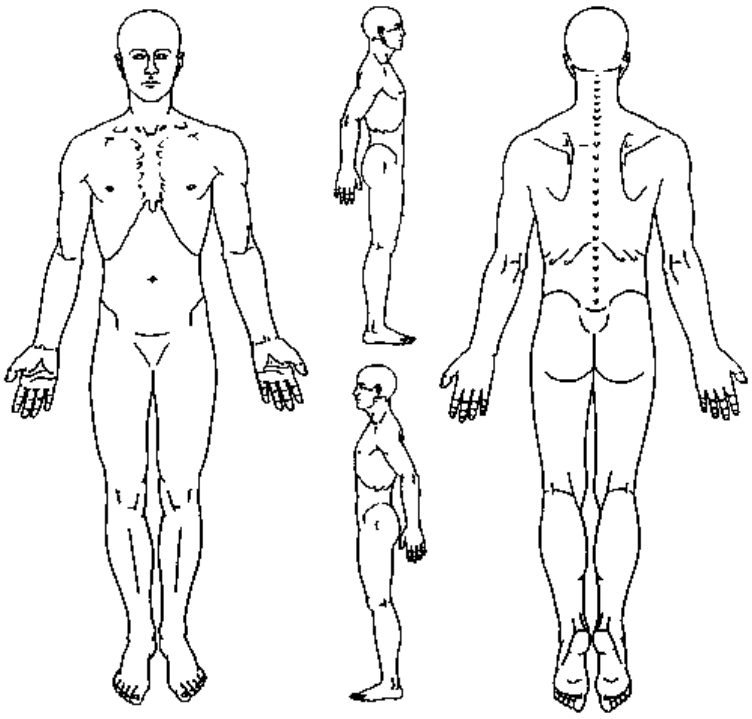
What makes you feel better?

☐ Sitting ☐ Lifting ☐ Heat
☐ Standing ☐ Lying ☐ Cold
☐ Bending ☐ Walking ☐ Other: _____

Please indicate the type(s) of pain you are feeling: ☐ Sharp ☐ Achy ☐ Numb ☐ Burning ☐ Tightness

Please circle the severity of your pain at this time: NO PAIN **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** WORST PAIN EVER

On the diagrams below use the symbol(s) and draw the location(s) of your pain: Sharp **O** Achy **X** Numb **+** Burning **^** Tightness **#**



INFORMED CONSENT

Physiotherapists treat pain originating from the musculoskeletal system of the human body. To do so physiotherapists perform examination procedures which may include orthopedic testing, palpation and neurological testing. Treatment may consist of soft tissue work, stretching, mobilization, manipulation and exercises. Adjunctive therapies such as T.E.N.S. interferential current and ultrasound and laser therapy may also be utilized.The physiotherapist and staff will always be available to answer questions and concerns, and discuss the nature and purpose of the procedures.I hereby request and consent to the performance of physiotherapy care. I understand that as in all health care certain risks may be associated with treatment, these including but not limited to, muscle strains/sprains, bruising and soreness. I do not expect the physiotherapist to be able to anticipate and explain all the risks and complications. I wish to rely on the physiotherapist to exercise judgment during the treatment based on my best interests. I have the opportunity to ask questions about the above mentioned physiotherapy procedures.

I have read and understood the above information and by signing below I consent to the above mentioned procedures. I intend this consent to cover the entire course of care for my present conditioned and for future care that I may seek.

I hereby authorize Target Therapeutics to obtain and review copies of any hospital, medical or other related health records and give permission for valid related information to be discussed with and released to other health professionals, insuring agents or employers involved in my rehabilitation program.

_____ DD / MM / YYYY
FULL NAME (PLEASE PRINT) DATE

_____
SIGNATURE

TARGET THERAPEUTICS

Pain - Prevention - Performance

VEHICLE INSURANCE INFORMATION

Date of Accident- YYYY-MM-DD _____-____-____

Name of car insurance company_____
Branch Location _____
Name of insurance adjuster _____

Insurer Telephone _____ - _____- _____
Insurer Fax _____ - _____- _____

Policy holders name □ same as above
Different Policy holder's name_____

Policy number - _____
Claim # (if known) _____

Are you seeing any other health practitioner for treatment as a result of this accident? (E.g. dentist, optometrist) □N □ Y If yes please list _____
_____

Were you employed at the time of the accident? □N □Y

- Do your injuries impact your work activities? □N □Y
  If Yes Please Explain: _____
  _____
- If you are unable to do your normal pre-accident employment activities, is your employer able to provide suitable modified work? □N □Y If yes please explain: _____
  _____

Do your injuries affect your everyday activities? □N □Y
If Yes Please Explain: _____
_____

Do you have Extended Health Benefits? □N □Y
If YES, go to the following page, If No go to page 3

Extended Health Benefit (EHB) Information

If you have EHB then you must complete the following information. If you have more than one policy then ask us for another copy of this page and you must fill this page out twice so that we know the details of you coverage for both policies. (through their work as well as through a spouse or common law partner, school etc.)

Insurance Company _____
Policy # / Plan #_____
Name of Plan Member_____
Member Id. _____

1- Do you have a maximum coverage amount/year for the following?

Chiropractic □N □Y max$/year $_____
Physiotherapy □N □Y max.$/year $_____
Massage □N □Y max.$/year $_____

Is there a max. dollar amount per treatment? □N □Y $_____
Is there a % coverage per treatment? □N □Y %_____
Does your policy have a maximum # of visits? □N □Y #_____

Do you have a flex amount that you can use for any practitioners that you choose □N □Y max.$/year $_____

Is there a max. dollar amount per treatment? □N □Y $_____
Is there a % coverage per treatment? □N □Y %_____
Does your policy have a maximum # of visits? □N □Y #_____

2- Month when your insurance renews (most commonly Jan.)_____

3- Do you have unlimited Physiotherapy coverage □N □Y
Is there a max. dollar amount per treatment? □N □Y $_____
Is there a % coverage per treatment? □N □Y %_____

Do you have unlimited Massage coverage □N □Y
Is there a max. dollar amount per treatment? □N □Y $_____
Is there a % coverage per treatment? □N □Y %_____

PATIENTRESPONSIBILITIES

FORMS

Your car insurance company will be mailing you some forms called the Accident Benefits Application Package or OCF1. It is your responsibility to fill out these forms promptly and send them back to your insurance company. Failure to do so may result in your treatments not being covered in which case it would be your responsibility to pay for your treatments rendered here at Target Therapeutics.

OTHER PRACTITIONERS

If during your treatment plan, you see any other health professionals other than the practitioners that you are seeing here at Target Therapeutics for the treatment of your motor vehicle accident injuries, it is your responsibility to tell us about it because it may affect the amount of treatments that you may receive.

SETTLEMENT

If you settle your claim with your insurer at any point during your treatment here at Target Therapeutics you must inform us of the **effective date** in order to avoid being charged for treatments rendered during your treatment plan or after your effective date. We must also be notified whether your balance will be paid by your insurance company or by you to us as a part of your settlement.

PAYMENT

Statutory Accident Benefits in Ontario dictate that you must use your Extended Health Benefits towards the payment of your MVA rehabilitation. You will be responsible to pay Target Therapeutics the amount of coverage that you have for all of the practitioners that you see treatment at our facility. If your treatment continues until after your yearly renewal date and you have a yealy CAP amount per practitioner or a FLEX plan, you will be required to pay us the amount of benefits that you have per practitioner before and after your renewal period.

Once this amount is paid, we will provide you with an invoice. It will be your responsibility to submit your claim and upon re-embursment from your extended health insurance company they will provide you with an explanation of benefits(EOB) document which will have to be given to us in order for us to process the balance of your account with the car insurance company. We require an EOB for each and every payment that is paid to us.

Name (printed)_____

Signature _____

Date _____

TARGET THERAPEUTICS

Pain - Prevention - Performance

Active Release Therapy

Chiropractic

Medical Acupunture

Massage Therapy

Pedorthic Services

- The following three pages of questionnaires ask about your ability to perform certain activities and how these activities affect your neck, low back and arms. Only answer the particular questionnaire if you have symptoms related to your MVA in that body area.
- They are designed to help us better understand how your pain allows you to manage through your activities of daily living.
- Please answer every question, based on how you presently feel by circling the appropriate number.
- If you have not performed the activity in the past week, please make your best estimate as to which response is the most accurate.
- Please sign and date each document in the appropriate locations.

NECK DISABILITY INDEX

THIS QUESTIONNAIRE IS DESIGNED TO HELP US BETTER UNDERSTAND HOW YOUR NECK PAIN AFFECTS YOUR ABILITY TO MANAGE EVERYDAY-LIFE ACTIVITIES. PLEASE MARK IN EACH SECTION THE **ONE BOX** THAT APPLIES TO YOU. ALTHOUGH YOU MAY CONSIDER THAT TWO OF THE STATEMENTS IN ANY ONE SECTION RELATE TO YOU, PLEASE MARK THE BOX THAT **MOST CLOSELY** DESCRIBES YOUR PRESENT-DAY SITUATION.

SECTION 1 - PAIN INTENSITY

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

SECTION 2 - PERSONAL CARE

- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally, but it causes extra pain.
- ❑ It is painful to look after myself, and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- ❑ I can lift heavy weights without causing extra pain.
- ❑ I can lift heavy weights, but it gives me extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor but I can manage if items are conveniently positioned, ie. on a table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light weights if they are conveniently positioned.
- ❑ I can lift only very light weights.
- ❑ I cannot lift or carry anything at all.

SECTION 4 – WORK

- ❑ I can do as much work as I want.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I can't do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

SECTION 5 – HEADACHES

- ❑ I have no headaches at all.
- ❑ I have slight headaches that come infrequently.
- ❑ I have moderate headaches that come infrequently.
- ❑ I have moderate headaches that come frequently.
- ❑ I have severe headaches that come frequently.
- ❑ I have headaches almost all the time.

SECTION 6 – CONCENTRATION

- ❑ I can concentrate fully without difficulty.
- ❑ I can concentrate fully with slight difficulty.
- ❑ I have a fair degree of difficulty concentrating.
- ❑ I have a lot of difficulty concentrating.
- ❑ I have a great deal of difficulty concentrating.
- ❑ I can't concentrate at all.

SECTION 7 – SLEEPING

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed for less than 1 hour.
- ❑ My sleep is mildly disturbed for up to 1-2 hours.
- ❑ My sleep is moderately disturbed for up to 2-3 hours.
- ❑ My sleep is greatly disturbed for up to 3-5 hours.
- ❑ My sleep is completely disturbed for up to 5-7 hours.

SECTION 8 – DRIVING

- ❑ I can drive my car without neck pain.
- ❑ I can drive as long as I want with slight neck pain.
- ❑ I can drive as long as I want with moderate neck pain.
- ❑ I can't drive as long as I want because of moderate neck pain.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I can't drive my care at all because of neck pain.

SECTION 9 – READING

- ❑ I can read as much as I want with no neck pain.
- ❑ I can read as much as I want with slight neck pain.
- ❑ I can read as much as I want with moderate neck pain.
- ❑ I can't read as much as I want because of moderate neck pain.
- ❑ I can't read as much as I want because of severe neck pain.
- ❑ I can't read at all.

SECTION 10 – RECREATION

- ❑ I have no neck pain during all recreational activities.
- ❑ I have some neck pain with all recreational activities.
- ❑ I have some neck pain with a few recreational activities.
- ❑ I have neck pain with most recreational activities.
- ❑ I can hardly do recreational activities due to neck pain.
- ❑ I can't do any recreational activities due to neck pain.

PATIENT NAME _____ DATE _____

SCORE _____ [50] BENCHMARK -5 = _____

Patient's Name_____ Number_____ Date_____

LOW BACK DISABILITY QUESTIONNAIRE (REVISED OSWESTRY)

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. **Please answer every section and mark in each section only ONE box** which applies to you. We realize you may consider that two of the statements in any one section relate to you, but **please just mark the box which MOST CLOSELY describes your problem.**

Section 1 - Pain Intensity

☐ I can tolerate the pain without having to use painkillers.
☐ The pain is bad but I can manage without taking painkillers.
☐ Painkillers give complete relief from pain.
☐ Painkillers give moderate relief from pain.
☐ Painkillers give very little relief from pain.
☐ Painkillers have no effect on the pain and I do not use them.

Section 2 -- Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain.
☐ I can look after myself normally but it causes extra pain.
☐ It is painful to look after myself and I am slow and careful.
☐ I need some help but manage most of my personal care.
☐ I need help every day in most aspects of self care.
☐ I do not get dressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

☐ I can lift heavy weights without extra pain.
☐ I can lift heavy weights but it gives extra pain.
☐ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table.
☐ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
☐ I can lift very light weights.
☐ I cannot lift or carry anything at all.

Section 4 – Walking

☐ Pain does not prevent me from walking any distance.
☐ Pain prevents me from walking more than one mile.
☐ Pain prevents me from walking more than one-half mile.
☐ Pain prevents me from walking more than one-quarter mile
☐ I can only walk using a stick or crutches.
☐ I am in bed most of the time and have to crawl to the toilet.

Section 5 -- Sitting

☐ I can sit in any chair as long as I like
☐ I can only sit in my favorite chair as long as I like
☐ Pain prevents me from sitting more than one hour.
☐ Pain prevents me from sitting more than 30 minutes.
☐ Pain prevents me from sitting more than 10 minutes.
☐ Pain prevents me from sitting almost all the time.

Scoring: Questions are scored on a vertical scale of 0-5. Total scores and multiply by 2. Divide by number of sections answered multiplied by 10. A score of 22% or more is considered significant activities of daily living disability.
(Score___ x 2) / (____Sections x 10) = _____ %ADL

Section 6 – Standing

☐ I can stand as long as I want without extra pain.
☐ I can stand as long as I want but it gives extra pain.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than 30 minutes.
☐ Pain prevents me from standing more than 10 minutes.
☐ Pain prevents me from standing at all.

Section 7 -- Sleeping

☐ Pain does not prevent me from sleeping well.
☐ I can sleep well only by using tablets.
☐ Even when I take tablets I have less than 6 hours sleep.
☐ Even when I take tablets I have less than 4 hours sleep.
☐ Even when I take tablets I have less than 2 hours sleep.
☐ Pain prevents me from sleeping at all.

Section 8 – Social Life

☐ My social life is normal and gives me no extra pain.
☐ My social life is normal but increases the degree of pain.
☐ Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing.
☐ Pain has restricted my social life and I do not go out as often.
☐ Pain has restricted my social life to my home.
☐ I have no social life because of pain.

Section 9 – Traveling

☐ I can travel anywhere without extra pain.
☐ I can travel anywhere but it gives me extra pain.
☐ Pain is bad but I manage journeys over 2 hours.
☐ Pain is bad but I manage journeys less than 1 hour.
☐ Pain restricts me to short necessary journeys under 30 minutes.
☐ Pain prevents me from traveling except to the doctor or hospital.

Section 10 – Changing Degree of Pain

☐ My pain is rapidly getting better.
☐ My pain fluctuates but overall is definitely getting better.
☐ My pain seems to be getting better but improvement is slow at the present.
☐ My pain is neither getting better nor worse.
☐ My pain is gradually worsening.
☐ My pain is rapidly worsening.

Comments_____

Reference: Fairbank, Physiotherapy 1981; 66(8): 271-3, Hudson-Cook. In Roland, Jenner (eds.), Back Pain New Approaches To Rehabilitation & Education. Manchester Univ Press, Manchester 1989: 187-204

*Quick*DASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

*Quick*DASH DISABILITY/SYMPTOM SCORE = $\left(\left[\frac{\text{sum of n responses}}{n}\right] - 1\right) \times 25$, where n is equal to the number of completed responses.

A *Quick*DASH score may <u>not</u> be calculated if there is greater than 1 missing item.