entire health

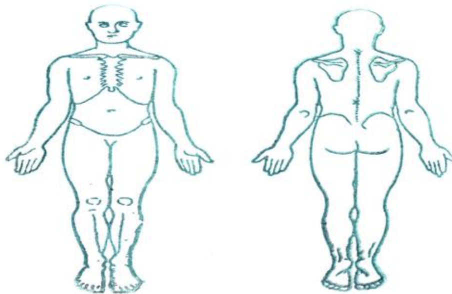
PHYSIOTHERAPY / EXERCISE PHYSIOLOGY / MASSAGE

Please READ CAREFULLY and answer as many questions as you can.

DATE: ___/___/____ **NAME:** ______________________ **DOB:** ____/____/____

MAIN AREA OF PAIN/INJURY: ____

Please indicate by circling/shading the areas where you have pain:



What makes it **worse**? ______________________________________

What makes it **better**? ______________________________________

Is it **worse** at any particular **time of day**? ______________________

Pain Rating Scale **At Worst** (Circle):

0 **1** **2** **3** **4** **5** **6** **7** **8** **9** **10**

Nil — Moderate — Excruciating

GENERAL HEALTH: (Circle) **Fair** **Good** **Excellent**

PHYSICAL ACTIVITY Please list all current and previous physical activities: __________________________

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CURRENT MEDICATIONS: ____

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MEDICAL HISTORY: –Past or Present (Circle)

***Heart Condition/Pacemaker**	***Chest pain/Angina**	***Epilepsy**	***Circulation problems**
***High/Low Blood Pressure**	***Diabetes**	***Pregnancy**	***Osteoporosis**
***Asthma/Respiratory Condition**	***Cancer**	***Arthritis**	***Spinal Injury/Degeneration**
***Stroke/Neurological condition**	***Thyroid condition**	***High Cholesterol**	***Allergies/Skin Condition**
***Undue Shortness of Breath**	***Anaemia**	***Fainting/Blackouts**	***HIV/Hepatitis**

If you have circled any of the above, please detail:____

____

PREVIOUS SURGICAL PROCEDURES: ____

____

DETAILS OF PREVIOUS TREATMENT: ____

____

YOUR GOALS AND EXPECTATIONS OF TREATMENT: ____