

ABOUT YOUR HEALTH

FILE #

FIRST NAME

PATIENT

LAST NAME

PLEASE CHECK THE PROBLEMS THAT APPLY TO YOU

SURGERIES

OSTEOPOROSIS

STROKE

ALLERGIES

THYROID

GOUT

METAL IMPLANT

HIGH BLOOD PRESSURE

DIABETES

PACEMAKER

HEART DISEASES

SMOKER

AIDS / HEPATITIS / HERPES

HIGH CHOLESTEROL

ALCOHOLISM / DRUG USE

PHLEBITIS / THROMBOSIS

BREATHING PROBLEMS

CANCER

DIZZINESS

INCONTINENCE

OTHER

FAINTING SPELLS

MULTIPLE SCLEROSIS

WOMEN

HEADACHES / MIGRAINES

RHUMATOID ARTHRITIS

PREGNANT

SEIZURES / EPILEPSY

PARKINSON DISEASES

C-SECTION

DO YOU TAKE ANY MEDICATION?

YES

NO

WHICH ONE?

ARE YOU?

RIGHT HANDED

LEFT HANDED

AMBIDEXTROUS

PHYSIOOUTAOUAIS
MÉDECINE DU SPORT

PATIENT'S SIGNATURE

PHYSIOTHERAPIST'S SIGNATURE

Please print the completed form and bring it with you to the clinic at your next appointment.