**Health Questionnaire**

Date of consultation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Female ❑ Male ❑

Name:

Date of Birth: ( ) Day • ( ) Month • ( ) Year • Age:

Address:

Town: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ • Province: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ • Postal Code:

Telephone • Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ • Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ext.

Cellphone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ • E-mail:

❑ **Yes,** you may contact me via e-mail to send appointment reminders, statements and any important information regarding the clinic.

❑ **No,** I do not want to be contacted via e-mail.

Occupation:

Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ • Relationship:

Emergency contact’s phone number:

**How did you hear about us?**

❑ Internet ❑ Portage ❑ Doctor:

❑ Other Health Professional:

❑ Recommendation from another client:

❑ Other:

**Médical Doctor:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ • Telephone:

X-rays, MRI, Ultrasound taken? ❑ Yes ❑ No • Date (if yes):

List medications you are taking and for what conditions:

Date of last medical exam:

What is your major complaint (pain/symptoms)?

Other complaint?

How long have you had this condition?

What are your goals for physiotherapy?

**Past Health History:**

Please check (🗹) if you have any of the following conditions. Please circle those conditions or symptoms which have been a problem to you in the past.

❑ Allergies ❑ Diabetes ❑ Loss of Weight

❑ Anxiety/Panic Attack ❑ Diarrhea ❑ Low Blood Pressure

❑ Arthritis ❑ Difficulty Breathing ❑ Nausea

❑ Asthma ❑ Dizziness ❑ Numbness

❑ Blurred Vision ❑ Fever ❑ Rashes

❑ Cancer ❑ Headaches ❑ Skin Problems

❑ Chest Pain ❑ Heart Condition ❑ Sweats

❑ Chronic Coughing ❑ Hernia ❑ Trouble Urinating

❑ Congestive Heart Failure ❑ High Blood Pressure ❑ Vomiting

❑ Constipation ❑ Kidney Infection ❑ Weakness

**Is there anything else we should know?**

**Thank you!**

**Consent for Joint Manipulation**

**Joint Manipulations** consist of a high velocity, low amplitude thrust on a bone to allow motion of a joint. It is a safe and effective method to reinstate motion in a joint and reduce the pain in your muscles in the surrounding area. There is often a “ POP ” or “ CLICK ”that may occur, this is simply air pressure releasing. Your physiotherapist will determine whether you are a suitable candidate for manipulation before this technique is performed. This decision will be guided by the results of your physical examination and knowledge of your relevant health history.

Mild temporary side effects can occur with joint manipulations. These include, but are not limited to, local discomfort, numbness, dizziness, and/or headaches. More serious side effects are much less frequent but can occur. These include, but are not limited to, worsening of symptoms, nerve or disk injury, fracture, and rarely, with neck manipulation, stroke and death. Estimates of the risk of serious side effects from a neck manipulation vary widely, 1/50 000 to 1/5.85 million, but the risk appears “ smaller than that associated with many commonly used diagnostic tests or prescription drugs. ”

**Joint manipulation** may not be appropriate if you:

\_\_\_ are pregnant \_\_\_ have a pacemaker or a heart condition

\_\_\_ have a collagen disorder \_\_\_ have a deficient bone density

\_\_\_ have ligament laxity \_\_\_ have a history of stroke

I hereby acknowledged that I have discussed with the physiotherapist the assessment of my condition and the treatment plan. I understand the nature of the treatment to be provided to me. I have considered the benefits and risks of treatment, as well as the alternatives to treatment. I hereby consent to joint manipulations as proposed to me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (Please print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20

Signature of patient (or legal guardian)