Physiotherapy

HealthTweak

Member # _____

PERSONAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____

Gender: _____ Preferred Pronoun: _____ Spouse/Partner: Y / N Children: Y / N #: _____

Address: _____ City: _____ Postal Code: _____

Home/Work Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

E-mail: _____ May we contact you via e-mail? Y / N

Medical Doctor: _____ Location: _____ Last Visit: _____

How did you hear about us? ☐ *Online* ☐ *Doctor/Nurse Practitioner* ☐ *Other:*_____

☐*Existing patient* _____

HEALTHCARE HISTORY

Have you ever seen? ☐ Chiropractor ☐ Physiotherapist ☐ Massage Therapist ☐ Naturopath

Date of last visit: _____ _____ _____ _____

Have you ever had? ☐ X- Ray ☐ MRI ☐ CT ☐ Ultrasound

WHAT IS THE NATURE OF YOUR VISIT?

☐ Wellness (to maintain the highest level of health)

☐ Restorative (to restore my health)

☐ Injury (to get out of pain)

Please explain your primary health challenges in order of importance to you:

1) _____

When did it begin? _____ Have you had this problem before? _____

This challenge started: ☐ Suddenly ☐ Gradually ☐ Unknown

Have you noticed any other symptoms associated with this challenge? _____

What does this challenge stop you from doing? _____

What treatments have you tried to help this challenge? _____

Physiotherapist Notes: _____

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2) _____

When did it begin? _____ Have you had this problem before? _____

This challenge started: ☐ Suddenly ☐ Gradually ☐ Unknown

Have you noticed any other symptoms associated with this challenge? _____

What does this challenge stop you from doing? _____

What treatments have you tried to help this challenge? _____

Physiotherapist Notes: _____

3) _____

When did it begin? _____ Have you had this problem before? _____

This challenge started: ☐ Suddenly ☐ Gradually ☐ Unknown

Have you noticed any other symptoms associated with this challenge? _____

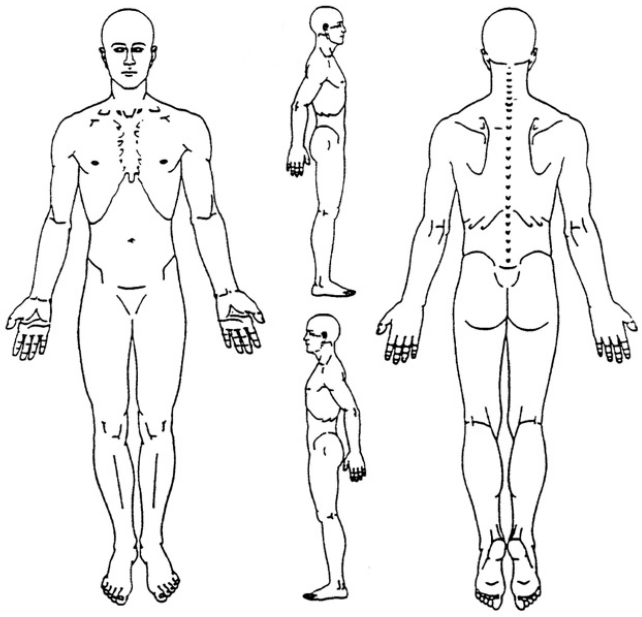
What does this challenge stop you from doing? _____

What treatments have you tried to help this challenge? _____

Physiotherapist Notes: _____

Use letters to indicate type and location of discomfort

A = Ache
B = Burning
S = Stabbing
N = Numbness
P = Pins & Needles



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Past Injuries

(Birth complication, congenital conditions, teen trauma, emotional trauma, severe stress, injuries, work injuries, car accidents, surgeries, broken bones, etc)

Emotional trauma: _____

Chemical trauma: _____

Physical trauma: _____

_____

Surgeries/Hospitalizations: _____

Health conditions treated for in the past year: _____

_____

Medication and Supplements

Please list any *medications* you are taking: *Purpose and dose*:

_____ _____

_____ _____

_____ _____

_____ _____

Please list any *supplements* you are taking: *Purpose and dose*:

_____ _____

_____ _____

_____ _____

_____ _____

Gynecology and Pregnancy

Age of first period: _____ Any chance you may be pregnant? Y ☐ N ☐ If so, # of weeks_____

First day of your last period? _____ How long does your period last? _____

How long is your cycle (first day of menses to last day before they start again)? _____

Are your menses? Irregular ☐ Painful ☐ Heavy ☐

Do you experience hot flashes? Y ☐ N ☐

Date of last PAP : _____ Normal cells ☐ Abnormal cells ☐

Are you using any method of birth control? If yes, what type?_____

How long have you been using this method? _____

Do you experience any changes with your body or emotions prior to your menses/period or at any specific point in your cycle? _____

Have you ever been pregnant? If yes;

# of live pregnancies _____ # of miscarriage _____ # of abortions _____

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HEALTH CONDITIONS

- ☐ Seizures
- ☐ Allergies _____
- ☐ HIV
- ☐ Rheumatoid Arthritis
- ☐ Diabetes
- ☐ Alcoholism
- ☐ Thyroid Disease
- ☐ Cystic Fibrosis
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Arthritis
- ☐ Other Major Illness
- ☐ Rheumatic Fever
- ☐ Cancer
- ☐ Venereal Disease
- ☐ Long COVID

General
- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Nausea/vomiting
- ☐ Fevers
- ☐ Lumps
- ☐ Masses
- ☐ Dizziness
- ☐ Double vision
- ☐ Problems swallowing
- ☐ Problems talking
- ☐ Loss of consciousness
- ☐ Loss of balance

Gastrointestinal
- ☐ Heartburn
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloating/Gas
- ☐ Laxative use
- ☐ Bad Breath
- ☐ Nausea/vomiting
- ☐ Abdominal cramps/pain
- ☐ Rectal Pain
- ☐ Hemorrhoids
- ☐ Blood in stool

Respiratory
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Coughing Blood
- ☐ Pneumonia
- ☐ Pain w/breathing
- ☐ Mucous Production

Learning Disability
- ☐ ADHD
- ☐ Dyslexia
- ☐ Memory loss
- ☐ Autism spectrum

Neuropsychological
- ☐ Depression
- ☐ Disinterest
- ☐ Anxiety
- ☐ Schizophrenia
- ☐ Eating Disorder
- ☐ Concussion
- ☐ Fainting
- ☐ Dizziness
- ☐ Neuropathy
- ☐ Numbness
- ☐ Neurological condition (MS, ALS)

Ear/Nose/Throat/Eyes
- ☐ Vision loss/blurring/pain
- ☐ Hearing loss/ringing
- ☐ Sinus infections/problems
- ☐ Ear infections
- ☐ Nose Bleeds
- ☐ Problems with teeth
- ☐ Night Blindness
- ☐ Sores on lips, tongue or m
- ☐ Facial Pain
- ☐ Recurrent sore throat

Genitourinary
- ☐ Increased frequency
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Discharge
- ☐ Kidney Stones
- ☐ Bladder/Yeast Infections
- ☐ Genital Sores
- ☐ Unable to hold urine
- ☐ Decrease in flow
- ☐ Urgency to void
- ☐ Wake at night to void

Cardiovascular
- ☐ Chest pain
- ☐ Stroke
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Pacemaker
- ☐ Heart Attack
- ☐ Irregular Heartbeat
- ☐ Swelling hands/feet
- ☐ Varicose Veins
- ☐ Blood Clots
- ☐ Impotence

Adrenal
- ☐ Mental fog
- ☐ Poor focus
- ☐ Quick to react
- ☐ Low energy
- ☐ Fatigue
- ☐ Headache
- ☐ Chest tightness
- ☐ Restless legs
- ☐ Susceptible to stress

Physiotherapist Notes
- ☐ Vascular
- ☐ Metabolic
- ☐ Aneurism
- ☐ Neoplasm
- ☐ Infection
- ☐ Congenital
- ☐ Trauma
- ☐ Other

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LIFESTYLE

What is the biggest stressor in your life? ☐ Family ☐ Work ☐ Social ☐ Financial ☐ Health ☐ Time

What do you love to do in your spare time (hobbies)? _____

How often do you exercise? ☐ Daily ☐ 3-5 days/week ☐ 1-2 days/week ☐ Infrequently

Smoke? Y / N # Packs/week _____ Drink alcohol? Y / N # Drinks/week _____

Recreational Drug use: _____

Hours of sleep? _____ Feel rested? _____

Where is your current level of health? (circle) Very low Poor OK Good Excellent

If you had excellent health, what would you love to be able to do? _____

FAMILY PROFILE

At Health*Tweak* we are here to help you and family live healthy and happy. Please mention below any health conditions or concerns they may have:

Children: _____

Spouse/Partner: _____

Other family members: _____

PERSONAL HEALTH INFORMATION CONSENT FORM

I understand that Health*Tweak* is my health information custodian. I consent to the collection, use and disclosure of my personal health information for treatment and other health care reasons. Health*Tweak* is a multidisciplinary clinic, and therefore treatment notes may be shared between practitioners to best treat the patient.

I understand that to provide me with Massage Therapy, Chiropractic, Physiotherapy, Naturopathic Medicine or any other health care services, Health*Tweak* will collect personal information about me (e.g. birth date, home contact information, health history, etc.)

I understand that Health*Tweak* will only collect, use, or disclose my personal health information with my express or implied consent; unless a collection, use, or disclosure without consent is permitted or required by law.

○ I give permission to HealthTweak to contact your primary healthcare provider such as my medical doctor, nurse practitioner ect.

Name: _____ Name of Witness: _____

Signature: _____ Date: _____

Thank you for completing this form.

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PHYSIOTHERAPIST EXTRA NOTES

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CONSENT TO PHYSIOTHERAPY ASSESSMENT AND TREATMENT

It is important for you to consider the benefits, risks and alternatives to the treatment options offered by your physiotherapist and to make an informed decision about proceeding with treatment.

Physiotherapy is a drug-free health care practice. Physiotherapists work in partnership with individuals of all ages to break down the barriers to physical function whether that means working with patients pre and post surgery, helping people come back from illness and chronic disease, injury, industrial and motor vehicle accidents and age-related conditions. Physiotherapists also play an important role in health promotion and disease prevention.

Physiotherapy treatment techniques may include, but are not limited to: manual therapy techniques including spinal and joint manipulation and mobilization, electrotherapeutic, thermotherapy or cryotherapy modalities and exercise. Other techniques such as functional dry needling, acupuncture and soft tissue therapy may also be utilized. A number of these may be recommended during your program of care.

Benefits

Physiotherapy treatment has been demonstrated to be effective for complaints of the neck, back and other areas of the body caused by nerves, muscles, joints and related tissues. Physiotherapy benefits include decreasing pain, improving joint mobility, increasing strength and coordination. It can also increase cardio-respiratory efficiency, improve function, and reduce or eliminate the need for drugs or surgery.

Risks

The risks associated with physiotherapy treatment vary according to each patient's condition as well as the location and type of treatment.

The risks include:

- **Temporary worsening of symptoms** – Usually, any increase in pre-existing symptoms of pain or stiffness will last only a few hours to a few days.
- **Temporary muscle soreness –** techniques used may cause muscle soreness which usually only lasts a few hours to a few days.
- **Skin irritation or burn** – Skin irritation or a burn may occur in association with the use of some types of electrical or light therapy. Skin irritation should resolve quickly. A burn may leave a permanent scar. Can also occur when pressure is applied to the skin or the use of needling technique.
- **Sprain or strain** – Typically, a muscle or ligament sprain or strain will resolve itself within a few days or weeks with some rest, protection of the area affected and other minor care.
- **Rib fracture** – While a rib fracture is painful and can limit your activity for a period of time, it will generally heal on its own over a period of several weeks without further treatment or surgical intervention. This would be most prominent in patients with decreased bone density.
- **Injury or aggravation of a disc** – Over the course of a lifetime, spinal discs may degenerate or become damaged. A disc can degenerate with aging, while disc damage can occur with common daily activities such as bending or lifting. Patients who already have a degenerated or damaged disc may or may not have symptoms. They may not know they have a problem with a disc. They also may not know their disc condition is worsening because they only experience back or neck problems occasionally.

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Physiotherapy treatment should not damage a disc that is not already degenerated or damaged, but if there is a pre-existing disc condition, physiotherapy treatment, like many common daily activities, may aggravate the disc condition.

The consequences of disc injury or aggravating a pre-existing disc condition will vary with each patient. In the most severe cases, patient symptoms may include impaired back or neck mobility, radiating pain and numbness into the legs or arms, impaired bowel or bladder function, or impaired leg or arm function. Surgery may be needed.

Risks Specific to Functional Dry Needling (FDN) and Acupuncture - The most serious risk with FDN or acupuncture is accidental puncture of a lung (pneumothorax) or other organs in the body. If this were to occur, it may likely require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe puncture can require hospitalization and re-inflation of the lung. This is a rare complication, and in skilled hands it should not be a major concern. Other risks include injury to a blood vessel causing a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern.

Health Tweak is a Multidisciplinary clinic; therefore other practitioners may have access to your file. If this poses any concern please let us know.

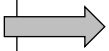
Alternatives
Alternatives to physiotherapy treatment may include consulting with other health professionals. Your physiotherapist may also prescribe rest without treatment, or exercise with or without treatment.

Questions or Concerns
You are encouraged to ask questions at any time regarding your assessment and treatment. Bring any concerns you have to the Physiotherapist's attention. If you are not comfortable, you may stop treatment at any time.

Please inform your Physiotherapist immediately of any change in your condition.

DO NOT SIGN THIS FORM UNTIL YOU MEET WITH THE PHYSIOTHERAPIST

I hereby acknowledge 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 physiotherapy treatment as proposed to me.



_____
Name *(Please Print)*

_____ _____
Signature of Patient (or legal guardian) Date

_____ _____
Signature of Physiotherapist Date