Hybrid Therapy & Training
#220 4808 87 Street
Edmonton, AB
T6E 0V3

MEDICAL HISTORY FORM

First & Last Name: _____ Date of Birth: _____ Age: _____

Home Address: _____ City: _____ Province: ____

Postal Code: _____ Email Address: _____

Primary Phone No:_____ Occupation:_____

Referring Physician (if applicable): _____ Dr.'s Diagnosis: _____

Please check if you have seen or are under the care of any of the following professionals:

___Medical Doctor ___Physical Therapist ___Chiropractor ___Psychologist/Psychiatrist

___Other: _____

Please check if you have had any of the following tests for your condition:

___X-Ray ___MRI ___CAT Scan ___Bone Scan ___Nerve/Muscle Test

___Other: _____

Please list any surgeries you have had and the dates:

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Procedure: _____ Date: _____

Please list any prescription medications you are currently taking:

Have you ever been diagnosed with any of the following? ***(Circle all that apply)*****:**

Asthma	Depression/anxiety	HIV/AIDS	Pneumonia
Arthritis	Diabetes	Joint pain	Psychological care
Back pain	Digestive problems	Kidney problems	Rheumatoid arthritis
Blood clots	Dizziness	Liver disease	Seizures/epilepsy
Blurred vision	Excessive/chronic fatigue	Lung problems	Shortness of breath
Bronchitis	Headaches	Migraines	Skin disease or sensitivity
Bowel problems	Heart problems	Neck pain	Stress/tension
Broken bones	Hemorrhoids	Neurological disorder	Stroke
Cancer	Hepatitis	Osteoporosis	Thyroid problems
Circulation problems	Hernia	Pacemaker	Vision/hearing problems
Concussion	High blood pressure	Paralysis	

Other: _____

WOMEN: Are you currently pregnant or think you may be pregnant? ___Yes ___No

What is your primary complaint? (location, onset, symptoms, progression, scale of 1-10)

Please list *<u>all</u>* previous injuries (any area of the body) and the year they occurred:

Are there any activities that you are having difficulty performing due to your condition?

What are your goals and expectations for treatment?

Other health questions:

I go to sleep easily: ___Yes ___No I sleep well: ___Yes ___No I get enough sleep: ___Yes ___No

On average I sleep ___ hours per night.

I have significant stress in my life: ___ Yes ___No I have strategies for managing my stress: ___Yes ___No

I like to exercise regularly: ___Yes ___No Preferred activities:_____

I am optimistic that my condition will improve: ___Yes ___No

I do hereby state that the above information is accurate and true to the best of my knowledge.

Name of Client: Signature of Client (or Guardian):

_____ _____

Date of Signature:

_____