Physical SOLUTIONS

In order for the practitioners to provide you with the best possible care the following confidential information must be completed.

Date: _____

Patient's Full Name:_____

Date of Birth:_____

Address:_____ Postal Code:_____

City:_____ Province:_____

Contact #: work/home/cell _____

Sex: M F Occupation:_____

How do your spend most of your day? Sitting / Standing / Both / Other:_____

Email Address:_____

How did you hear about me or Referred by:_____

What is your main concern _____

When did it begin?_____

Have you had this or a similar complaint before?_____ If yes, explain:

_____

What makes it worse?_____

What makes it better?_____

How severe is the pain?

0 1 2 3 4 5 6 7 8 9 10

(no pain) (extreme Pain)

When does it hurt?_____

How long does it last?_____

Physical SOLUTIONS

Does the pain interfere or stop you from doing any of the following: (circle all that apply)

Work Sleep Daily routine Recreation
Sitting Standing Walking Lying down Bending
Specific motions(explain):_____

Have you received any other treatment for your complaint?_____ If yes, please specify from the following:

Massage Therapy Medical Doctor Physiotherapist Chiro
Surgeon Other:_____

What did you find helps the most? _____

Are there any other concerns/complaints?_____

Past History: Describe Date

Surgeries:_____

Injuries:_____

Auto accidents:_____

Hospitalizations:_____

Major illnesses:_____

Are you currently taking any medications? (include asprin, ibuprofen, antihistamines, birth control, supplements, etc…)

_____

_____

Do you have any allergies?

_____

Do you have any medical conditions? (circle all that apply)

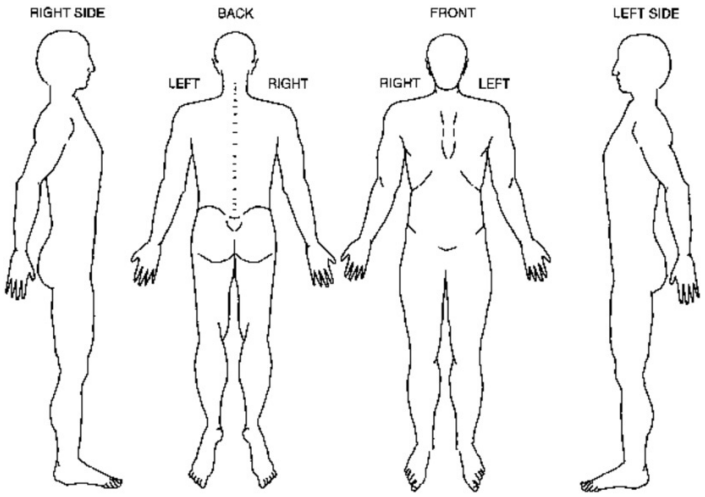
Diabetes Asthma Heart conditions Epilepsy Hernia
Arthritis Cholesterol Eye problems Hearing loss Thyroid
Ulcer High or Low Blood Pressure

Name of your medical Doctor:

_____

Physical SOLUTIONS

Mark any areas of your body that you have had or experienced discomfort/pain/injury in the past year.



REVIEW OF SYSTEMS

Circle any of the following that you currently have or have experienced in the past 6 months:

GENERAL Nervousness Irritability Depression Fatigue Sleep disturbances Change in weight Fever	**CHEST** Chest pain Shortness of breath Pain around ribs Cough	**MID BACK** Mid back pain Pain b/w shoulder blades Sharp stabbing pain Muscle spasms
HEAD Headache Entire head Back of head Forehead Temples Migraine Head trauma Dizziness Fainting Light headed Memory loss	**NOSE** Nosebleeds Sinus problems **EYES** Change in vision Glasses/contacts Blurry vision Double vision Flashes in vision Spots in vision Sensitive to Light	**MOUTH/JAW/THROAT** Jaw pain Change in taste Hoarseness Trouble swallowing Slurring speech **EARS** Ringing in ears Hearing loss Frequent infection Ear pain Bussing in ears Drainage

Other:

_____

_____

_____

What are the main goals you want to accomplish with your visit(s) to Physical Solutions:

1._____

2._____

3._____

Fee Guidelines

Initial Assessment (Mini - Full)	$120 - 250.00/session
Follow Ups	$85.00 - $150.00/session

** 3, 6 & 1 year Packages Available Ask For Details*

_____ ***Cancellations without 24-hour notice and no shows will result in a charge***
initial ***for the scheduled session***

WAIVER

I have stated all medical conditions that I am aware of and will update the practitioner of any changes in my health status. I agree to immediately inform the therapist if I experience any pain or discomfort during my treatment/training session so that the rehabilitation/treatment/training can be adjusted to my level of comfort. I assume all risks and responsibilities from any injury or liability that may occur as a result of this session.

Date:_____

Signature:_____