IRELAND MANUAL PHYSIOTHERAPY

Name:_____
DOB:_____ Age:_____
Height/Weight:_____

Confidential Health History Form

Injury/Present Concern

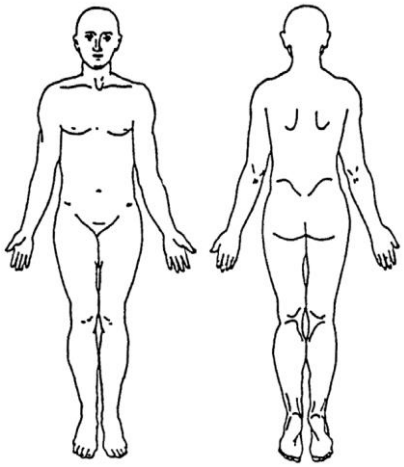
Area (s) of injury/concern:

Date of injury/surgery:

Have you seen anyone about this? ☐ Yes ☐ No
If yes, please list:

In the past 24 hours, what is your pain from 0-10 (0: no pain; 10: worst possible pain)?
Typical pain:_____
Best pain:_____
Worst pain:_____

Please indicate where you are feeling pain/discomfort.



Do you have other symptoms besides pain? ☐ Yes ☐ No
If yes, please elaborate:

Have you had any imaging or diagnostics performed? If yes, please describe:

Medical Screen

Do you presently, or have you ever suffered from any of the following?

☐ Heart Problems	☐ Broken bones/fractures	☐ Anemia	☐ Muscular weakness
☐ Angina/Chest Pain	☐ HIV/AIDS/Hepatitis	☐ Nutrient deficiency	☐ Chronic low back concerns
☐ Pacemaker	☐ MRSA/VRE	☐ Epilepsy/Seizures	☐ Chronic mid back concerns
☐ High Blood Pressure	☐ Tuberculosis	☐ Fainting Spells	☐ Chronic neck concerns
☐ High Cholesterol	☐ Rheumatic Fever/Polio	☐ Loss of sensation	☐ Dizziness/Vertigo
☐ TIA/Stroke	☐ Kidney Problems	☐ Chronic fatigue	☐ Night pain
☐ COVID 19	☐ Skin disease or sensitivity	☐ Fibromyalgia	☐ Fever/Chills
☐ Cancer	☐ Open sores/skin lesions	☐ Headaches	☐Numbness/tingling
Where/when?	☐ Depression/Anxiety	☐ Poor sleep/insomnia	☐ Trouble seeing
_____	☐ Mental Health Disorder	☐ Nausea/vomiting	☐ Trouble hearing
☐ Diabetes	☐ Asthma	☐ Unplanned weight loss/gain	☐Thyroid Problems
☐ Osteoporosis	☐ Emphysema/Bronchitis	☐ Pelvic Pain/Incontinence	☐ Repeated Infections
☐ Osteopenia	☐ Shortness of Breath	☐ Urinary Tract Infections	☐ Are you pregnant?
☐ Arthritis	☐ Chronic cough	☐ Kidney Disease/Stones	☐ Bowel/bladder problems

Do you have any allergies? ☐ Yes ☐ No
If yes, please list:

Are you currently seeing a health care professional? ☐ Yes ☐ No
If yes: who/for what reason?

Past Injuries/Surgeries

Please list all major injuries and past surgeries and the corresponding year (including dental procedures).

Ireland Manual Physiotherapy
Each Day is an Opportunity to be Better

Name:_____
DOB:_____

Confidential Health History Form

Medications/Supplements	
Please list all of the medications and supplements that you are currently taking and the reason why.	

Substance Use
Tobacco: ☐ Yes ☐ No If yes: How many cigarettes per day?
Alcohol: ☐ Yes ☐ No If yes: How many drinks per day/week?
Other:

Social History
Do you work? ☐ Yes ☐ No ☐ Retired ☐ Full time ☐ Part time Occupation:
Hobbies/Leisure Activities:
Do you exercise? ☐ Yes ☐ No If yes, please elaborate:
Do you have stress in your life? Please rate your stress from 0-10 (0: not stressed; 10: extremely stressed):
Please rate your current job satisfaction from 0-10 (0: extremely unsatisfied; 10: very satisfied):
How hopeful are you, from 0-10 that you will improve in the next 3 months? (0: not hopeful; 10: very hopeful):
Why is it important to you that you are cared for by Ireland Manual Physiotherapy?
Do you feel that people are not taking you and your injury/condition serious enough? ☐ Yes ☐ No
Do you feel that there is something dangerously wrong with your body? ☐ Yes ☐ No

Goals		
What are you looking to achieve with physiotherapy intervention?		
☐ Reduce Pain ☐ Improve Mobility	☐ Increase Strength ☐ Return to work/sport/leisure	☐ Return to everyday activities ☐ Other:
Do you have any specific questions you would like answered? ☐ Yes ☐ No		
Client Signature:		Date:
Physiotherapist signature after reviewed:		