Patient Information Sheet

Who referred you to Bosscher Physiotherapy?_____

Name:_____Date:_____
Date of Birth:_____Age:_____E-mail:_____
Address:_____
Home Phone:_____Cell Phone:_____
Occupation:_____Work Phone:_____

Please check if you currently have, or have ever had any of the following:

__Heart Disease	__Asthma	__Diabetes	__Difficulty Sleeping
__Heart Attack or Bypass	__Allergies	__Cancer	__Bowel/Bladder Problems
__Pacemaker or Defibrillator	__COPD	__Thyroid Disease	__Multiple Sclerosis (MS)
__High Blood Pressure	__Shortness of Breath	__Hepatitis	__Parkinson's Disease
__Blood Clot in Leg or Lung	__Gastrointestinal Problems	__HIV/AIDS	__Stroke
__Osteoporosis	__Osteoarthritis	__Depression	__Fall with injury
__Osteopenia	__Rheumatoid Arthritis	__Fainting	__Broken Bones
			__Chronic Pain

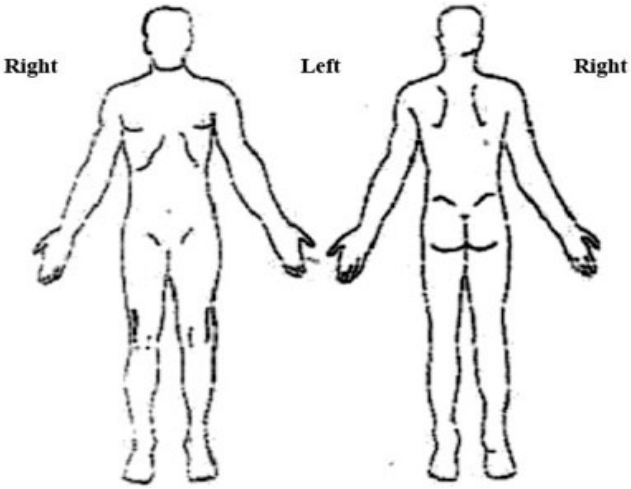
Are you Pregnant? __Yes __No Other:_____

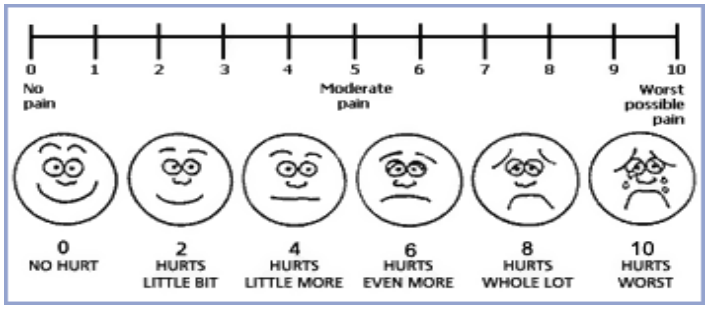
List any relevant past surgical history with dates:_____ _____

Are you currently taking any medications? ___Yes ___No If yes, please list _____
_____

Rate your overall health: __poor__fair__good__excellent

Pain Diagram: Mark with an "x" where your pain is located.





Pain Scale: Now_____ Worst_____ Best_____

What bothers you most: ____pain ____ loss in function?

What are your primary goal(s) to obtain from physiotherapy?

1._____ 2. _____ 3._____

_____
Patient Signature