# HELIOS REHABILITATION & PERFORMANCE

1605 Victoria Rd. W, Unit 5
Box 1998, Revelstoke, BC, V0E 2S0
phone: 250.837.7171
fax: 250.837.7161
email: clinic@heliosphysio.com
web: www.heliosphysio.com

## Confidential Patient History Form

Name: _____
Address: _____
_____
_____
Phone: (home): _____
(cell): _____
(work): _____
Email: _____
Occupation: _____

Birthdate: _____
Care card #: _____
Family Doctor: _____
Referring Professional: _____
Phone: _____
Extended Medical Insurer: _____
ICBC or WCB? (circle), Claim #: _____
How did you hear about our clinic? _____

I authorize Helios Rehabilitation & Performance and its associated therapists to collect my personal and medical information as documented above in order to contact me, and give permission for the clinic to leave messages regarding appointments at any of the contact numbers I have provided above. In addition, I authorize the clinic and its associated therapists to communicate with my referring MD as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

Please note: Your appointment time has been reserved for you. In courtesy of your therapist & fellow clients, we ask that you provide us with 24 hours notice of cancellation, otherwise a cancellation/no-show fee of $25 will be charged. Payment for all treatment, whether private or insured, is ultimately the responsibility of the client.

Signature: _____ Date: _____

Name & signature of parent/guardian if client is under 18: _____

## Medical History

Please indicate if you believe if any of the following apply to you. (P = past, C = current)
Please also indicate any medication you are taking for the conditions listed below.

| Yes | No | | |
|---|---|---|---|
| ☐ | ☐ | High/Low Blood Pressure | ☐ Altace (ramipril) ☐ Hydrochlorothiazide ☐ Metoprolol ☐ Adalat |
| ☐ | ☐ | Heart Condition | |
| ☐ | ☐ | Stroke or Aneurysm | |
| ☐ | ☐ | Asthma/Other Respiratory Condition | ☐ Corticosteroids ☐ Ventolin |
| ☐ | ☐ | Diabetes | ☐ Insulin |
| ☐ | ☐ | Epilepsy/Other Seizures | |
| ☐ | ☐ | Arthritis | ☐ Celebrex ☐ Arthrotec |
| ☐ | ☐ | Osteoporosis | ☐ Fosamax |
| ☐ | ☐ | Artherosclerosis | |
| ☐ | ☐ | Hemophilia | |
| ☐ | ☐ | High Cholesterol | ☐ Lipitor ☐ Crestor |
| ☐ | ☐ | Major infection/cellulitis | ☐ Gentamicin |

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Cancer |
| ☐ | ☐ | Hepatitis |
| ☐ | ☐ | HIV |
| ☐ | ☐ | Kidney Disease |
| ☐ | ☐ | Implants |
| ☐ | ☐ | Transplant |
| ☐ | ☐ | Corrective Lenses/Contacts |
| ☐ | ☐ | Depression/Anxiety |
| ☐ | ☐ | Allergies (please specify) |

_____

## Confidential Patient History Form (page 2)

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Varicose Veins |
| ☐ | ☐ | Bruise Easily |
| ☐ | ☐ | Haemophilia |
| ☐ | ☐ | Other Circulatory Condition |
| ☐ | ☐ | Skin Condition |
| ☐ | ☐ | Currently pregnant |
| ☐ | ☐ | Chronic Sinusitis |
| ☐ | ☐ | Hearing Loss |

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Headaches / Migraines |
| ☐ | ☐ | Dizziness / Fainting / Vertigo |
| ☐ | ☐ | Nausea |
| ☐ | ☐ | Changes in vision |
| ☐ | ☐ | Difficulty Swallowing |
| ☐ | ☐ | Speech Difficulty / Change |
| ☐ | ☐ | Change/loss of bowel/bladder |
| ☐ | ☐ | Urinary Condition |
| ☐ | ☐ | Irritable Bowel / Colitis / Other Digestive Condition |
| ☐ | ☐ | Other Neurological Condition |

Please list any other **prescription or non-prescription** medications (including herbal supplements, vitamins, etc...) you presently take. Please also indicate the frequency:

_____

_____

Do you have any family history of medical conditions? Yes No

_____

## Injury History

| Please indicate if you have ever: | Yes | No |
|---|---|---|
| Given birth? | ☐ | ☐ |
| Have you had any... | | |
| Major falls? | ☐ | ☐ |
| Motor vehicle accidents? | ☐ | ☐ |
| Concussions? | ☐ | ☐ |
| Dislocations/bone fractures? | ☐ | ☐ |
| Major accidents or illnesses? | ☐ | ☐ |
| Ligament sprains? | ☐ | ☐ |
| Muscle strains? | ☐ | ☐ |
| Other muscle/bone/joint problems? | ☐ | ☐ |
| Other surgeries? | ☐ | ☐ |
| Hospitalized for any other reason? | ☐ | ☐ |

If yes, please indicate how many times and whether birth was natural or c-section:

_____

Please provide details for any boxes checked:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

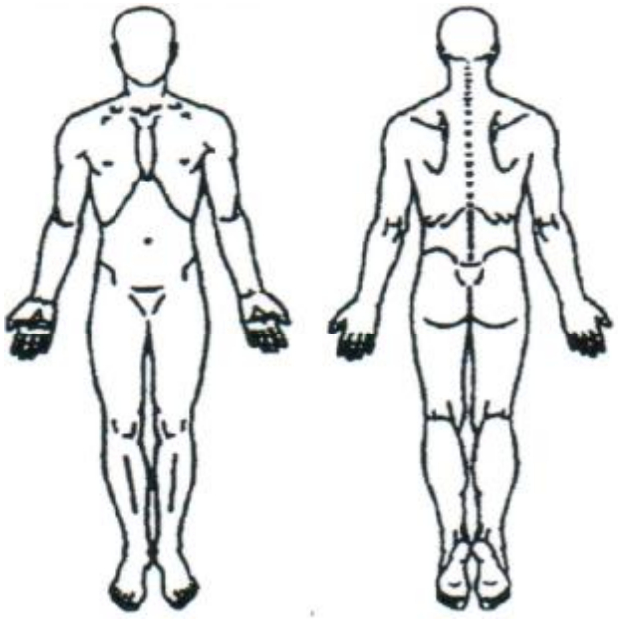
Other therapy / treatments: (past or present, does not have to be related to this visit)

| | Area(s) treated | Past | Current |
|---|---|---|---|
| ☐ Massage Therapy | _____ | ☐ | ☐ |
| ☐ Chiropractor | _____ | ☐ | ☐ |
| ☐ Physiotherapy | _____ | ☐ | ☐ |
| ☐ Naturopath | _____ | ☐ | ☐ |
| ☐ Acupuncture | _____ | ☐ | ☐ |
| ☐ Other _____ | _____ | ☐ | ☐ |

**Confidential Patient History Form (page 3)**

## Current Condition

Please indicate on the diagram the nature of your symptoms, using the symbols indicated:



Aching ○ ○
Stabbing X X X
Shooting → →
Burning # # #
Numbness or Tingling ≈ ≈

How long have you had this condition?

_____

_____

How did it start?

_____

_____

_____

_____

_____

What aggravates it?

_____

_____

Do you wake from the pain? y / n Are you able to fall back to sleep? y / n How?

What relieves it? (circle) Movement - Change in position - Heat - Ice - Medication
Topical Creams - Other: _____

Other notes:

_____

_____

_____

Have you had any imaging/diagnostic tests done? ie: X-ray, CT scan, MRI, Ultrasound, Bloodwork

_____

Please list any activities, sports, hobbies:

_____

Please circle the answer closest to how you PRESENTLY feel : (1 = poor, 5 = excellent)

| | | | | | |
|---|---|---|---|---|---|
| Quality of Sleep | 1 | 2 | 3 | 4 | 5 |
| Energy Level | 1 | 2 | 3 | 4 | 5 |
| Eating Habits | 1 | 2 | 3 | 4 | 5 |
| Stress Level | 1 | 2 | 3 | 4 | 5 |
| Exercise Habits | 1 | 2 | 3 | 4 | 5 |

Hours of sleep per night (approx.): _____

Preferred sleep position: _____

Number of meals you regularly eat per day: _____

Number of times you exercise per week: _____

Are you right or left-handed? _____