



719 Seymour Street, Kamloops, BC V2C 2H4 Phone: 250.682.4477 Fax: 778.471.4472

### Medical History

Name: \_\_\_\_\_ Date of Next Med. Appointment: \_\_\_\_\_

Describe briefly the history of your present accident, injury, illness or condition:

Onset Date: \_\_\_\_\_ Description: \_\_\_\_\_

Please list any special concerns, questions or expectations: \_\_\_\_\_

\_\_\_\_\_

Have you fallen in the past year? Yes / No If so, how many times? \_\_\_\_\_

Did you sustain an injury from falling? \_\_\_\_\_

Have you had any physical therapy during the current calendar year? Yes / No Have you had physical therapy for the same condition for which you are here today? Yes / No If yes, please indicate where and when: \_\_\_\_\_

List ALL medications you currently take: \_\_\_\_\_

Please list recent diagnostic studies (CAT scan, MRI, x-ray, etc.) and where taken: \_\_\_\_\_

\_\_\_\_\_

Do you have METAL anywhere in your body (other than teeth)? \_\_\_\_\_

Please list ALL surgeries you have had and dates, if possible: \_\_\_\_\_

\_\_\_\_\_

Have you ever had: (Please circle yes or no)

High blood pressure	Yes / No	Arthritis/Osteoarthritis	Yes / No
Heart disorders	Yes / No	Osteoporosis	Yes / No
High Cholesterol	Yes / No	Cancer	Yes / No
Lung Disorders	Yes / No	Pacemaker	Yes / No
Circulation disorders	Yes / No	Are you pregnant?	Yes / No
Dizzy Spells	Yes / No	Allergies to tapes or lotions?	Yes / No
Seizures	Yes / No	Tobacco use?	Yes / No
Diabetes	Yes / No		

Signature: \_\_\_\_\_

Date: \_\_\_\_\_