Guelph Rehab Centre
INNOVATIVE HEALTHCARE

MEDICAL HISTORY

Patient Name:	
Primary Complaint(s):	**Symptom(s):**

Please check all the following conditions that you experience or experienced:

Head/Neck
- Headache ☐
- Vision Problems ☐
- Tinnitus ☐
- Dizziness / Fainting ☐
- Balance Problems ☐

Respiratory
- Shortness of Breath ☐
- Asthma ☐
- Other: _____

Cardiovascular
- High Blood Pressure ☐
- Low Blood Pressure ☐
- Pacemaker ☐
- Other: _____

Allergies (please specify):

_____

Skin
- Skin Condition ☐
- Type: _____
- Bruise Easily ☐

Allergies (please specify):

_____

Other Conditions
- Anxiety / Depression ☐
- Arthritis ☐
- Bladder / Bowel ☐
- Cancer ☐
- Diabetes / Hypoglycemia ☐
- Digestive Problems ☐
- Epilepsy ☐
- Fibromyalgia ☐
- Loss of Sensation ☐
- Osteoporosis ☐
- Recent Weight Loss ☐
- Other: _____

Women
- Menstrual Problems ☐
- Pregnant ☐
- Due Date (D/M/Y) ___/___/___
- Other: _____
- Menopausal ☐

Any infectious disease(s):

_____

Other: _____

Medical Devices/Equipment:
- Pins ☐
- Wires ☐
- Plates ☐
- Artificial Joints/Limbs ☐
- Wheelchair ☐
- Walker ☐
- Cane ☐
- Dentures ☐
- Glasses ☐
- Contact Lenses ☐
- Hearing Aids ☐
- Other (please specify) ☐

_____

Social History
- Smoking ☐
- Alcohol Use *daily* ☐
- *socially* ☐
- Regular Exercise ☐
- Employment (Circle one) ☐

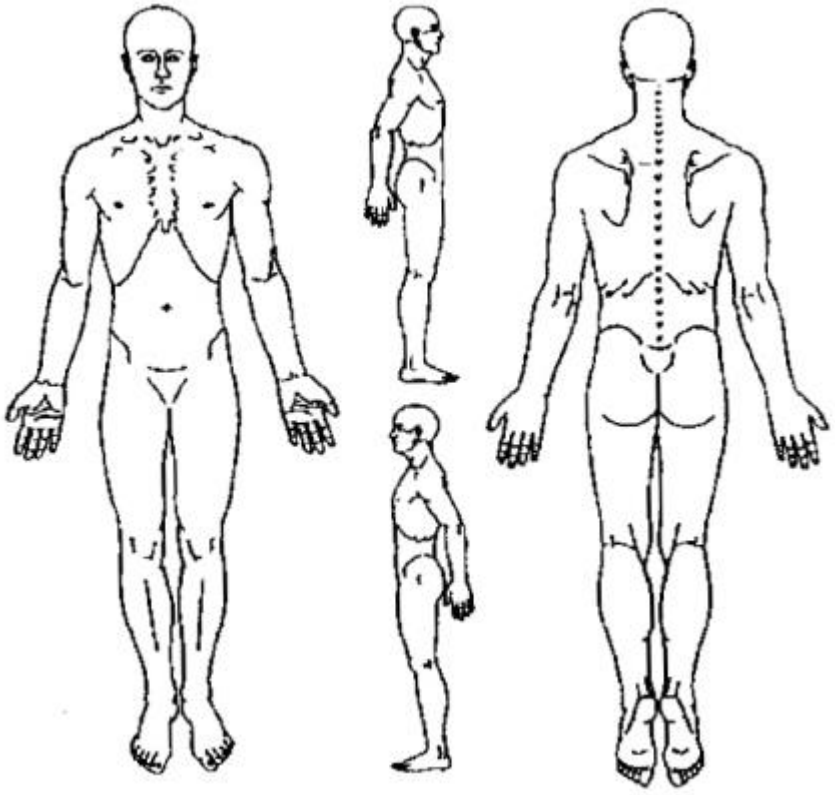
(FT) (PT) (Unemployed)

Current Medications/Surgeries/Past Injuries

(Please list names of medications and for what conditions, types of surgeries/past injuries and dates):

See Page 2

MEDICAL HISTORY



On drawing, please mark the area(s) of pain or unusual feeling with the following symbols:

- • Numbness
- × Burning
- o Tingling
- v Sharp Pain
- / Aching/Tension

On average, how intense has your pain been? Circle one.

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain possible

What makes it better?	What makes it worse?

SIGNATURE: Date :