ACTIVEREHAB CENTRE

TEL: 416.321.3969
FAX: 416.321.6517
EMAIL: INFO@ARCENTRE.CA
WWW.ARCENTRE.CA
2240 MIDLAND AVE, UNIT 103-104
TORONTO, ONTARIO, M1P 4R8

PATIENT HEALTH CONDITION FORM

PATIENT INFORMATION

*Last name:	*First name:	*Age:

*Sex: (Circle one) Male Female Prefer not to answer	Height: (Please note the unit as well – cm, ft, etc.)	Weight: (Please note the unit as well – lbs, kgs, etc.)	Interested in weight loss?: ☐ Yes ☐ No

INJURY INFORMATION

*What is your major symptom/concern?:

*When did your symptoms begin?:	*Have you had this problem before?:	*Is your condition getting progressively worse?:

*This problem is:
☐ Constant
☐ Comes and goes

*What is the severity of your pain on a scale of 0-10?:
(Circle one)
No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

*How does it feel?:
☐ Aching ☐ Burning ☐ Dull ☐ Sharp ☐ Shooting
☐ Stiff ☐ Swelling ☐ Tingling ☐ Throbbing ☐ Other: _____

What makes your condition better?:	What makes your condition worse?:

*Does it interfere with your:
☐ Work ☐ Recreational Activities/Sports ☐ Daily Routine ☐ Sleep

MEDICAL HISTORY & INFORMATION

Have you had any: Please note the date if yes to any of the below, and any relevant details.

Automobile accidents?:	Surgeries?:	Broken bones?:	Falls/Major injuries?:

Are any of the following stressors a constant in your life: Please note the intake/relevant information if yes to any of the below.

Smoking?: (Please note your intake – ex: packs/day)	Alcohol?: (Please note your intake – ex: drinks/week)	Coffee/Caffeinated Drinks?: (Please note your intake – ex: cups/day)	High Stress Level?: (Please note the reason)

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*Please check any of the following conditions you have/had:

- ☐ Aids/HIV
- ☐ Allergies
- ☐ Anxiety/Depression
- ☐ Arm/Shoulder Pain
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Problems
- ☐ Cancer
- ☐ Chronic Fatigue
- ☐ Deafness
- ☐ Diabetes
- ☐ Digestion Problems
- ☐ Earache
- ☐ Ear Ringing
- ☐ Epilepsy
- ☐ Headaches/Migraines
- ☐ Heart Disease
- ☐ Hemorrhoids
- ☐ Herniated Disk
- ☐ High Blood Pressure
- ☐ Insomnia
- ☐ Irregular Cycle
- ☐ Kidney Problems
- ☐ Leg Pain
- ☐ Lower Back Pain
- ☐ Neck Pain
- ☐ Osteoporosis
- ☐ Poor Circulation
- ☐ Prostate Problems
- ☐ Rheumatoid Arthritis
- ☐ Sciatica
- ☐ Shingles
- ☐ Sinus Infection
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ TMJ
- ☐ Venereal Disease
- ☐ Vertigo/Dizziness
- ☐ Other: _____

Family History of:

- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Problems
- ☐ High Blood Pressure

Females: You may skip this section if you select No below.

*Are you pregnant?:

☐ Yes ☐ No

Activities that are painful to perform:

☐ Sitting ☐ Standing ☐ Walking ☐ Lying Down ☐ Bending ☐ Getting Up ☐ Driving ☐ Reading

Are you currently taking any medications?:

☐ Yes – if yes, what? _____ ☐ No

AGREEMENT

I confirm that the information I have provided in regards to my current condition and past health history are to the best of my knowledge. I also acknowledge that it is my responsibility to update the clinic in regards to any changes in my health condition. I also authorize the release of my medical condition to my family physician.

_____ _____

Patient/Guardian signature Date