NAME: _____ **Date of Birth:** _____

ADDRESS: _____

HEALTH SCREENING QUESTIONNAIRE

The health information requested on the following form will assist us in treating you safely. If you have any questions about the requested information, please feel free to ask.

Primary reason for your visit? _____

Do you currently have or have previously had any of the following conditions?

- ☐ Diabetes
- ☐ Gynaecological Conditions
- ☐ Cancer
- ☐ Stroke/CVA
- ☐ Hepatitis
- ☐ Broken Bone
- ☐ Epilepsy Other
- ☐ Kidney Problems _____
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Allergies
- ☐ Thyroid Problems
- ☐ Arthritis
- ☐ Lung Conditions
- ☐ HIV/AIDS
- ☐ Skin Conditions
- ☐ Heart Disease _____
- ☐ Other _____

Current Medications:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

For Women:

1. Do you have any children? ☐ Yes ☐ No
2. Have you had a C-Section? ☐ Yes ☐ No
3. Are you currently pregnant? ☐ Yes ☐ No

Have you had any surgeries? Please provide details:

_____

_____

Do you currently (or within the past year) have any of the following symptoms?

- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Difficulty Swallowing
- ☐ Unexplained Weight Change
- ☑ Loss of Appetite
- ☐ Fevers/Chills/Sweats
- ☐ Unrelenting Night Pain
- ☐ Urinary/Bowel Problems
- ☐ Metal implant
- ☐ Depression
- ☐ Heart Palpitations
- ☐ Headache/ Migraines
- ☐ Loss of Balance/Co-ordination
- ☐ Speech Disturbances
- ☐ Dizziness/Blackouts
- ☐ Numbness in any part of your Body
- ☐ Weakness in Arms and Legs
- ☐ Seizures
- ☐ Pacemaker
- ☐ Anxiety

Please tell us what your three (3) primary goals are or what you wish to achieve at Physiomobility?

1. _____
2. _____

SEMI Thornhill
1-8150 Yonge St.
Thornhill, ON L4J 1W5
Tel #; 289-459-7364
Fax #: 905-731-3336

SEMI Sheppard
2-601 Sheppard Ave East
Toronto, ON M2N 5Y7
Tel #: 416-223-7364
Fax #: 416-223-8048

SEMI St. Clair
410-40 St. Clair Ave
Toronto, ON M4V 1M2
Tel #: 416-927-7364
Fax #: 647-930-9536