advantage physiotherapy
& sports injury clinic

Patient Name: ______________________________ **Date:** ________________
Date of Birth:_______________________________

Do you or have you ever experienced the following:

Cancer; where:____________ Osteoporosis
Diabetes Recent change in bowel/bladder functions
Arthritis Difficulty swallowing
Unexplained weight loss Numbness/tingling in groin

Do you have a pacemaker? YES NO
Are you pregnant? YES NO

Please list the medications you currently take:

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Do you have any other health condition or symptom (ex: high blood pressure, recent surgery, dizziness, etc.)?

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PLEASE CIRCLE YOUR INJURY