Health History Form

Patient Name: _____ **Hospital Green Card #:** _____
If no Green Card then D.O.B._____
dd/mm/yyyy

Date of Birth (dd/mm/yyyy): _____

Address: _____

Telephone (H): _____ **(W):** _____ **(C):** _____

Email address: _____

Preferred method of appointment reminder: ☐ Email ☐ Phone call

Where did you first hear about us?
☐ doctor ☐ internet ☐ pamphlet ☐ friend ☐ former patient ☐ other _____

Did someone refer you? ☐ Yes ☐ No
If yes, who? _____

Doctors:	**Name:**	**Address:**
Family Doctor	_____	_____
Referring Physician	_____	_____
Specialist	_____	_____

What are you seeking treatment for? _____

Have you or are you seeing any other health care practitioner(s) for this problem?

If yes, who? _____

Lifestyle

	Never	Occasionally	Weekly	Daily		Never	Occasionally	Weekly	Daily
Smoke	☐	☐	☐	☐	Meditate/Yoga	☐	☐	☐	☐
Drink Alcohol	☐	☐	☐	☐	Feel Stressed	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Sleep Well	☐	☐	☐	☐
Drink Caffeine	☐	☐	☐	☐	Have Fun	☐	☐	☐	☐

Occupation: _____ Height: _____ Weight: _____ BMI: _____

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Please list all physical activities you participate in on a regular basis:

Activity:	Days per week:	Hours per day:

Please list all surgical operations, starting with the most recent:

Operation:	Surgeon:	Date (dd/mm/yyyy):

Please complete the following table, if applicable:

Test:	Region of body:	Date (mm/yyyy):
Ultrasound		
X-ray		
CT Scan		
MRI		
Bone Scan		
Echocardiogram		

Do you have any allergies? ☐ Yes ☐ No

If yes, please specify: _____

_____

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Please list all medications:

Medication name:	Dose:	Reason for use:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please indicate if you current have, or have had, any of the following conditions:

☐ Congestive Heart Failure	☐ HIV	☐ Fibromyalgia
☐ Heart Attack	☐ Infectious Conditions	☐ Hearing Loss
☐ Heart Diseases	☐ Tuberculosis	☐ Hot Flashes
☐ Pacemaker	☐ Rheumatoid Arthritis	☐ Kidney Disease
☐ Stroke	☐ Osteoarthritis	☐ Depression
☐ High Blood Pressure	☐ Osteoporosis	☐ Varicose Veins
☐ Low Blood Pressure	☐ Degenerative Disc Disease	☐ Bowel Incontinence
☐ Respiratory Disease	☐ Digestive Issues	☐ Bladder Incontinence
☐ Vascular Disease	☐ Skin Conditions	☐ Vaginal Dryness
☐ Thyroid Disease	☐ Hepatitis	☐ Cancer
☐ Diabetes	☐ Epilepsy	☐ Other:_____

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Please answer the following questions if you have, or have had, a diagnosis of cancer.
If not, proceed to the next section:

Doctors:	**Name:**	**Address:**
Surgeon	_____	_____
Medical Oncologist	_____	_____
Radiation Oncologist	_____	_____
Type of Cancer:	_____	Affected side: ☐ Right ☐ Left
Did you have surgery for your cancer?		☐ Yes ☐ No
If yes, date of surgery:	_____	Type of surgery: _____
Did you have lymph nodes removed?		☐ Yes ☐ No
If yes, # removed:	_____	# positive: _____
Did you, or will you receive radiation treatments?		☐ Yes ☐ No
If yes, # of treatments:	_____	Start date: _____
Did you or will you receive chemotherapy treatment?		☐ Yes ☐ No
If yes, # of cycles:	_____	Start date: _____

Emergency Contact

Name: _____ Relationship: _____

Phone number: _____

I have read, understood, and have had the opportunity to discuss the:

☐ Release of information form
☐ The privacy policy
☐ The clinic's fee and payment schedule
☐ The cancellation policy

My signature below indicated my understanding of all of the above information and policies listed above:

_____ _____
Signature Date (dd/mm/yyyy)

OUR COMMITTMENT TO PRIVACY

Haley Rehab is committed to protecting the privacy, confidentiality and security of all personal information to which it is entrusted.

Federal and provincial privacy legislation reiterate the importance of privacy and require that Haley Rehab tell you how your personal information is used, how it is protected, and how one can access it.

WHY DO WE COLLECT YOUR PERSONAL INFORMATION?

Haley Rehab collects information about our patients so that they can be accurately identified each time they visit. Personal information that is collected is only available to the staff who are involved with your treatment either directly (physiotherapists, massage therapists) or in a supporting role (administration staff).

WHEN DO WE DISCLOSE YOUR PERSONAL INFORMATION?

Personal information may be disclosed to the following persons or agencies:

- A care provider within your circle of care. Examples include your attending doctor and family doctor.
- You, your legal representative, or next of kin. Your personal information can be disclosed to someone that you have designated to act on your behalf in the event that you are unable to do so.
- A public authority (such as a lawyer) where it is legally required to do so.
- A health regulator agency (such as Ministry of Health and Long-Term Care or Health Canada) if health regulations or laws require health information.
- Any third party (such as your private insurance company or lawyer) provided you have consented to the disclosure or the law requires the disclosure.

HOW DOES HALEY REHAB PROTECT YOUR PERSONAL INFORMATION?

Your personal information will be protected with an appropriate set of safeguards:

- Physical – such as locked doors
- Technical – such as passwords and firewalls
- Administrative – such as privacy policies

RELEASE OF INFORMATION

I hereby grant permission for Haley Rehab to release and obtain pertinent information regarding my condition from and to physiotherapists, oncologists, physicians and other health care professionals involved in my care.

LATE CANCELLATION / MISSED APPOINTMENT POLICY

Last minute (less than 24 business hours notice) cancellations and missed appointments are subject to an insufficient notice fee in the amount of the full appointment. Please notify us a minimum of 24 business hours in advance if you will be unable to attend your appointment.