HALIFAX YOGA
FITNESS + WELLNESS

PHYSIOTHERAPY MEDICAL INTAKE FORM

Health History (Please circle all that apply to you.)

Heart problems

Pacemaker

Arthritis

High blood pressure

HIV / AIDS

High cholesterol

Kidney problems

Stroke

Repeated infections

Lung problems

Thyroid problems

Cancer

Skin disease or sensitivity

Diabetes

Depression

Anxiety

Osteoporosis

Asthma

Broken bones / fractures

Epilepsy / Seizures

Any other medical condition not listed

_____

_____

Are you or could you be pregnant? _____

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Allergies:

_____

_____

If any of the above are circled please provide details:_____

_____

_____

_____

Have you had any surgeries? (Please list)

_____

_____

Current medications:_____

_____

What is your major complaint/area of pain?_____

_____

_____

Signature: _____ Date: _____