HaleyRehab

PRE-ASSESSMENT HEALTH HISTORY FORM

Date: D____/ M____ / Y____

Name: ____ **D.O.B.:** ________________

Address: ____

Tel: (H) __________________ **(W)** __________________ **Other** __________________

Email Address: ____________________________________

Doctors	Name	Address
Medical Oncologist:		
Radiation Oncologist:		
Surgeon:		
Family Doctor:		

What are you seeking treatment for? ____

How long have you had this problem? ____

Type of cancer, if applicable: ____

Did you have surgery for your cancer condition? ❑ Yes ❑ No

Type of surgery: ____

Which side was affected: ❑ Right ❑ Left **Date of surgery:** ______________

Did you have lymph nodes removed? ❑ Yes ❑ No

 # removed ______________ **# positive** ______________

Did you or will you receive radiation treatments? ❑ Yes ❑ No

# of radiation treatments? __________ **Start date:** ____________________________

Did you or will you receive chemotherapy treatment? ❑ Yes ❑ No

# of chemotherapy cycles? ____________ **Start date:** ____________________________

Have you seen or are seeing any other health care practitioner(s) for this complaint? ❑ Yes ❑ No

❑ **doctor,** ❑ **physiotherapist,** ❑ **chiropractor,** ❑ **massage therapist,** ❑ **acupuncturist,** ❑ **other**

Have you ever had other injuries, fractures or surgeries? (Please date & list) ❑ Yes ❑ No

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____

List any drugs or medication you are taking at the present time and their use:(including non-prescription drugs, supplements, injections…)

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

Do you have any allergies (medications, environmental, skin sensitivities)? ❑ Yes ❑ No

__________________________ __________________________ __________________________

Please indicate any medical conditions (past or present)

❑ Heart Attack	❑ Rheumatoid Arthritis	❑ Special equipment / aids ______________________
❑ High Blood Pressure	❑ Osteoarthritis	❑ Epilepsy / Seizures
❑ Low Blood Pressure	❑ Osteoporosis	❑ Thyroid Disease
❑ Stroke / CVA	❑ Degenerated Discs	❑ Varicose Veins
❑ Pace maker	❑ Multiple Sclerosis (MS)	❑ Kidney Disease
❑ Heart / Vascular	❑ Fibromyalgia	❑ Hepatitis
❑ Respiratory problems ______________________	❑ Hot flashes	❑ Currently smoking
❑ Infectious conditions	❑ Digestive/Intestinal Disorders	❑ Other ______________________
	❑ Diabetes	
	❑ Tuberculosis	

LATE CANCELLATION / MISSED APPOINTMENT POLICY

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

***** INITIALS BELOW DENOTES THESE TERMS HAVE BEEN READ AND UNDERSTOOD *****

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Client Initials

RELEASE OF INFORMATION AND CONSENT TO TREATMENT

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

______________________ ______________________ ______________________

Date **Print Name** **Client Signature**

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