**MEDICAL HISTORY:**

|  |  |  |  |
| --- | --- | --- | --- |
| **NAME:** | Click or tap here to enter text. | **DATE:** | Click or tap here to enter text. |
| **DOB:**  **AGE:** | Click or tap here to enter text.  Click or tap here to enter text. | **SEX:** | FEMALE MALE OTHER  DECLINE |
| **ADDRESS:**  **POSTAL CODE:**  **PROVINCE:** | Click or tap here to enter text.  Click or tap here to enter text.  Click or tap here to enter text. | **CONTACT**  **DETAILS:** | T:Click or tap here to enter text.  C:Click or tap here to enter text.  W:Click or tap here to enter text.  E:Click or tap here to enter text. |
| **EMERGENCY CONTACT** | Click or tap here to enter text. | **CONTACT**  **DETAILS:** | T:Click or tap here to enter text.  C:Click or tap here to enter text.  W:Click or tap here to enter text.  E:Click or tap here to enter text. |
| **RELATION TO CLIENT:** | Click or tap here to enter text. | **MARITAL STATUS:** | SINGLE MARRIED  DIVORCED  WIDOWED |
| **OTHERS LIVING AT HOME:** | CHILDREN: Click or tap here to enter text. | **OTHER:** | Click or tap here to enter text. |
| **CLIENT’S EMPLOYEMENT** | Click or tap here to enter text. | **WORK:** | FULL TIME PART-TIME  STUDENT RETIRED  UNEMPLOYED |
| **SPORTS OR HOBBIES:** | Click or tap here to enter text. | **INTERESTS:** | Click or tap here to enter text. |
| **PRIMARY CARE PHYSICIAN:** | Click or tap here to enter text. | **PHONE NUMBER:** | Click or tap here to enter text. |
| **SPECIALIST:** | Click or tap here to enter text. | **PHONE NUMBER:** | Click or tap here to enter text. |

**PRIMARY DIAGNOSIS**:Click or tap here to enter text.

**CONDITIONS WHICH REQUIRE IMMEDIATE OR EMERGENCY CARE** (allergies, epilepsy, diabetes, respiratory challenges etc.)

1. Click or tap here to enter text. TREATMENT: Click or tap here to enter text.
2. Click or tap here to enter text. TREATMENT:Click or tap here to enter text.
3. Click or tap here to enter text. TREATMENT: Click or tap here to enter text.

**MEDICATIONS:**

1. Click or tap here to enter text. 4. Click or tap here to enter text.
2. Click or tap here to enter text. 5. Click or tap here to enter text.
3. Click or tap here to enter text. 6. Click or tap here to enter text.

**RECEIVING HOME ASSISTANCE:** YES NO

**CHECK ANY OF THE MEDICAL CONDITIONS THAT APPLY TO YOU:**

Depression /mental health challenges Neurological Diseases /Disorders Heart problems Degenerative Disease Osteoporosis Obesity Muscle/Tendon Injury  Circulation/Vascular problems Joint ReplacementJoint Replacement Stroke/ Transient Ischemic Attack Fractures Alzheimer’s / Dementia Arthritis Diabetes

Breathing Seizures / epilepsy Cancer Headaches Back Pain Head Injury

**Please provide details regarding any of the medical conditions you identified above**:Click or tap here to enter text.

**Recent/Relevant Surgery**:Click or tap here to enter text.

**Medications**:Click or tap here to enter text.

**Any other tests, x-rays, scans etc.,**Click or tap here to enter text.

**Contraindications / Precautions:**

None Seizure disorder Braces / orthopedics

Osteoporosis Pacemaker or other implants

Lifting/ weight limitations Cardiac Hip/back

Breathing other

**Please describer your concerns**:Click or tap here to enter text.

**What do you hope to accomplish with therapy services**?Click or tap here to enter text.

**List any questions you would like support with**:Click or tap here to enter text.

**THANK YOU!**

The information provided will inform supports and services from your Occupational Therapist.

If this questionnaire was not completed through Park Integrative Health on the Jane App, then please email completed questionnaire to:

[shamalamanilall@gmail.com](mailto:shamalamanilall@gmail.com)