**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 Replacement[ ] Joint 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