**Specific Medical Problems Please indicate (YES or NO)**

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| **Blood Pressure** | ☐ | ☐ | **Hepatitis B/ AIDS (Self /Family)** | ☐ | ☐ |
| **Pacemaker** | ☐ | ☐ | **Ulcer / Hiatus Hernia** | ☐ | ☐ |
| **Cardiac Surgery** | ☐ | ☐ | **Pregnancy** | ☐ | ☐ |
| **Diabetes** | ☐ | ☐ | **Cancer:** | ☐ | ☐ |
| | | | **(Radiotherapy)** | ☐ | ☐ |
| | | | **(Chemotherapy)** | ☐ | ☐ |
| **Epilepsy** | ☐ | ☐ | **Psychological Disorder (eg: depression, anxiety)** | ☐ | ☐ |
| **Asthma** | ☐ | ☐ | **Previous Surgeries/Arthroscopy (give details)** | ☐ | ☐ |

**Previous Surgeries/Arthroscopy:** _____

**Allergies:** _____

**Recent Medication:** _____

**Have you had previous physiotherapy for this injury: Yes** ☐ **No** ☐

**If yes what has been most beneficial?** _____

**What has aggravated the condition?** _____

**** If you fail to advise our practice of your non-attendance there will be $35 dollars cancellation fee**

**Patient Signature:** _____ **Date:** _____