Synergy Sports Medicine
235 Wallace Avenue
toronto, ontario
M6H 1V5
416.703.3525

Information in this form is confidential and will only be used by **Synergy Sports Medicine** assessment purposes.

Name: ____ Phone (home): __________________

Address: ____ Phone (work): __________________

__________________________ Postal Code ___________ email: ________________________

Date of birth: _________________ Occupation: ____

Doctor's Name: __________________________________ MD phone: ____________________

How did you hear about **Synergy Sports Medicine**? ____

Health History

Please check the conditions that you are experiencing or have experienced in the past.

Head / Neck

____ Headaches
____ Vision Problems
____ Contact Lenses
____ Earaches

Respiratory

____ Chronic Cough
____ Shortness of Breath
____ Smoking
____ Breathing Problems, spec.

____

Cardiovascular

____ High blood pressure
____ Low blood pressure
____ Poor circulation
____ Heart disease
____ Phlebitis
____ Stroke
____ Varicose veins
____ Heart palpitation
____ Anemia
____ Atherosclerosis

Skin

____ Skin conditions, spec.

____

____ Bruise easily

Infections

____ Hepatitis
____ Herpes
____ Plantar warts
____ TB
____ HIV, AIDS
____ Other, spec

____

Women's Health

____ Menstrual problems/pain
____ Caesarean section
____ Gynecological surgery

____

____ Pregnant: Due date _______
____ Children: number _____
____ Menopausal problems

Surgery

Type: ____________________

Date: ____________________

Current symptoms: ____________

____

Current Medications

Name(s) and for what conditions:

____

____

____

Other Conditions

____ Digestion difficulties
____ Constipation
____ Liver disease
____ Gall bladder disease
____ Kidney disease
____ Bladder dysfunction
____ Diabetes
____ Allergies
____ Sinus
____ Insomnia
____ Cancer
____ Arthritis, which joints?

____

Are you currently receiving treatment from:

____ Massage therapist
____ Physiotherapist
____ Osteopath
____ Chiropractor
____ Naturopath
____ Homeopath
____ Acupuncturist
____ Midwife
____ MD
____ Other _____________

Are you currently experiencing any muscle pain or stiffness and/or joint discomfort in the following areas?

____ Neck
____ Upper back
____ Shoulders
____ Arms: R or L
____ Wrists: R or L
____ Mid back
____ Low back: R or L
____ Sacroiliac joint
____ Hip: R or L
____ Buttocks / sciatica
____ Knee: R or L
____ Ankle: R or L
____ Plantar fascia / arches
____ Toes, spec. ________________________

Are you currently or have you in the past experienced any of the following?

____ Broken bone, spec.____

____ Sprains, ligamentous issues spec.____

____ Disc issues, spec. ____

____ Nerve issues, nerve referral, spec. ____

____ Do you have any surgically implanted metal plates or other, spec. material and where ______________________

____

____ Have you been diagnosed with scoliosis, structural ____ or functional ____ what level _______________________

____ Do you have any structural abnormalities i.e. extra vertebrae, spec. ____

____ Have you been diagnosed with a leg length discrepancy, structural ____ or functional ____

____ Do you wear orthotics?

Exercise Related History

Are you currently or have you in the past been involved in any of the following activities?

____ Pilates
____ Yoga
____ Tai chi
____ Martial arts
____ Skiing
____ Skating
____ Running
____ Aerobics
____ Weight training
____ Spinning
____ Alexander
____ Feldenkrais
____ Swimming
____ Stair Master
____ Gymnastics
____ Classical ballet
____ Other (s), please spec. ____

What are you hoping to accomplish by attending classes at Synergy Sports Medicine?

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Signature: ____ Date: ___________________________