Sam Hughes Physiotherapy
Women's & Men's Health

www.samhughesphysiotherapy.com
info@samhughesphysiotherapy.com

Client's information

Name: ____

Date of Birth: __/__/_____ (dd/mm/yyyy) Family Physician or Specialist: ___________________

Address: ____

Phone number: (day time) ______________________ E-mail: _________________________

Reason for consult: ____

Surgical History: ____

Medications: ____

Past Medical History - Please circle what applies to you:

Multiple Sclerosis, Stroke, Parkinson's, Acute Brain Injury, Trauma to the Pelvis or Lower Back, Diabetes, Pace Maker, Cancer, Sexually Transmitted Disease, Chronic Pain (indicate where _________________), Motor Vehicle Accident (MVA), Heart Disease, Anxiety, Depression, Lung Disease, Allergies (please indicate what type ________________________)

Investigations such as Cystoscopy, Ultra Sound, Urodynamics: ___________________________

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Any additional information pertinent to this consult: ___________________________________

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