Mary Liougas
Anna Markell
Physiotherapists

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Toronto, ON, M2K 1E6
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Personal Information

Last Name: _____First Name: _____Gender: M / F D.O.B _____

Address: _____

City: _____Province: _____ Postal Code: _____

Phone: Home: (____) _____Business: (_____) _____ext:_____Cell: (_____)_____

Email: _____

Emergency Contact: (Name and Telephone Number) _____

Family Physician (Name/ Phone Number/ Address) _____

Confidential Health Screening Questionnaire

Please indicate if you have any of the following (please circle):

Diabetes	Fractured Bones	Cancer	Lung Conditions
Kidney Problems	Hepatitis	Heart Disease	Thyroid Problems
Osteoporosis	Asthma	Epilepsy	Skin Conditions
Stroke/CVA	HIV/AIDS	Other: _____	Allergies _____

Have you ever had any surgeries? If yes, then please provide details _____

Please indicate if you have any of the following conditions (please circle):

Chest Pain	Unexplained Weight Loss	Heart Palpitations
Difficulty Swallowing	Loss of Balance/Co-ordination	Shortness of Breath
Speech Disturbances	Weakness of Arms or Legs	Dizziness/Blackouts
Fevers/Chills/Sweats	Numbness in any body part	Loss of Appetite
Night Pain	Urinary/Bowel Problems	Vomiting/Nausea