

Dear New Patient,

Please complete the following questionnaire as fully and carefully as possible. Your answers will help us to process your file, determine the nature of your complaint, and decide how best to assist you. This information will remain strictly confidential.

PERSONAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____ M / F
 (dd/mm/yyyy)

Mailing Address: _____

Home Telephone: _____ Business Telephone: _____ Cell: _____

Email: _____ Family Doctors Name: _____ Phone Number: _____

Occupation: _____ Emergency Contact Name: _____
 Phone Number & Relation: _____

How were you referred to our clinic? _____ OHIP Number: _____

CURRENT HEALTH STATUS

What are you seeking treatment for? _____

Have you had this injury/condition before? Yes No If yes, when: _____

Did you seek therapy for it? Yes No If yes, what kind: _____

Was this a motor vehicle accident (MVA) or a workplace injury? Yes No

How long has the condition been bothering you? _____

Have you had any imaging for this condition (X-ray, CT scan, MRI) ? Yes No

If yes, when and where? _____

Are there any other conditions you would like to discuss? _____

Please list any **medications or supplements** you are currently taking and the reason for taking them:

Please list any previous **surgeries, hospitalizations, fractures, or accidents/traumas** (include year):

Please indicate which of the following you are currently experiencing or have experienced in the past by writing **C** (for current) or **P** (for past) where applicable.

CARDIOVASCULAR

☐ Stroke
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Circulatory Disorders
☐ Varicose Veins
☐ Pacemaker
☐ Phlebitis
☐ Heart Disease
☐ Chronic Congestive Heart Failure
☐ Myocardial Infarction

RESPIRATORY

☐ Emphysema
☐ Asthma
☐ Chronic Cough
☐ Bronchitis
☐ Breathing Difficulty
☐ Lung Disorder

NEUROLOGICAL

☐ Epilepsy
☐ Multiple Sclerosis
☐ Loss of Sensation
☐ Neuritis
☐ Other _____

DIGESTIVE & URINARY

☐ Chronic Abdominal Pain
☐ Prolonged Constipation
☐ Diarrhea
☐ Frequent Urination
☐ Irritable Bowel Syndrome
☐ Ulcerative Colitis/Crones
☐ Pelvic Inflammatory Disease
☐ Gastritis
☐ Liver / Gall Bladder
☐ Kidney / Bladder Disease

SKIN

☐ Bruise Easily
☐ Eczema / Psoriasis
☐ Rash
☐ Cold Sores / Warts
☐ Herpes
☐ Athlete's Foot
☐ Loss of Sensation
☐ Other _____

HEAD & NECK

☐ Headache
☐ Migraine
☐ Visual Disturbances
☐ Earaches
☐ Hearing Problems
☐ Teeth / Jaw Pain
☐ Locked Jaw
☐ Sinus Pain
☐ Injury
☐ Dizziness / Vertigo

SOFT TISSUE & JOINTS

☐ Neck ☐ Hip
☐ Shoulder ☐ Leg
☐ Arm / Elbow ☐ Knee
☐ Chest ☐ Ankle
☐ Abdomen
☐ Upper Back
☐ Mid Back
☐ Lower Back

GENITOURINARY

☐ Hemorrhoids
☐ Prostate Problems
☐ Sexual Dysfunction
☐ Hernias

☐ Menstrual Problems
☐ Menopausal Problems
☐ Endometriosis
☐ Previous C-Section
☐ PCOS

OTHER

☐ Allergies
☐ Arthritis
☐ Cancer
☐ Carpal Tunnel Syndrome
☐ Chronic Fatigue Syndrome
☐ Diabetes
☐ Fainting
☐ Fibromyalgia

☐ HIV / AIDS
☐ Hemophilia
☐ Hepatitis
☐ Insomnia
☐ Osteoporosis
☐ Scoliosis
☐ Tuberculosis

INJURIES

☐ Muscle Strain
☐ Ligament Sprain
☐ Fracture
☐ Whiplash
☐ Herniated Disc
☐ Other: _____

SURGICAL IMPLANTS

☐ Pins
☐ Plates
☐ Artificial joints:
☐ Other: _____

Other Conditions Not Listed Above: _____

Has anyone in your **family** had any of the following conditions (please specify whom):

Heart disease _____	High blood pressure _____
Cancer _____	Diabetes _____
Stroke _____	Arthritis _____
Other _____	

Please indicate how often you take part in these activities in an average week:

Exercise (type) _____	days/wk _____	Do you wear orthotics Yes No
Consume Alcohol _____	drinks/wk _____	How long have you had this pair? _____
Consume Caffeine _____	drinks/wk _____	
Smoking (please circle past/present)	packs/wk _____	

If you previously smoked please indicate how long you have quit for? _____

Name: _____

Date: _____

On the diagram provided below please mark the areas on your body which you feel best represent the pain(s) or sensation(s) you are experiencing. Please include all areas. Use the symbols provided below.

SYMBOLS:

Numbness zzzzzz

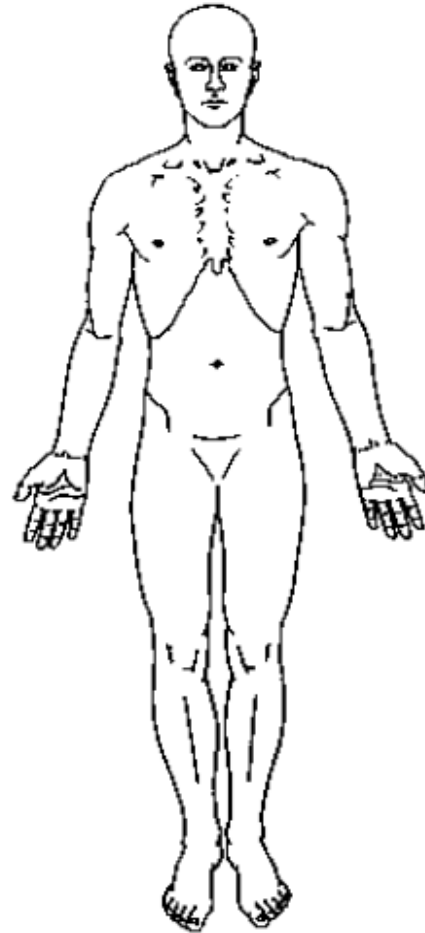
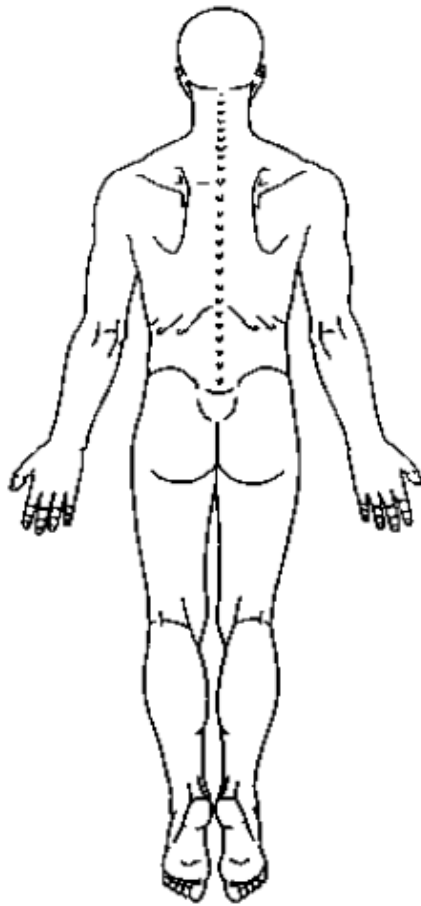
Pins & Needles

Dull & Aching ///////////////

Burning xxxxxxxx

Sharp & Stabbing oooooo

Stiff and Tight +++++++



What movements/activities are especially aggravating to your pain? _____

What movements/activities make you feel more comfortable? _____

Is your pain getting ☐ better? ☐ worse? ☐ staying relatively constant?

Rate the following by circling a number:

Level of pain **now:** None 0 1 2 3 4 5 6 7 8 9 10 Worst ever felt

Level of pain **at its worst:** None 0 1 2 3 4 5 6 7 8 9 10 Worst ever felt