

PERSONAL INFORMATION

Name: _____ Today's Date: _____
Date of Birth: _____ Gender: Male Female
Address: _____ Province & Code: _____
Home Phone: _____ Health Card #: _____
Marital Status: Single Married Widowed Divorced
Number of Children: _____ Ages: _____
Emergency Contact: _____ Phone: _____

Do you see a Physiotherapist/Chiropractor? Yes No
Physiotherapist/Chiropractor: _____ Date of last visit: _____

WORK RELATED INJURY

Did this injury occur during regular working hours? Yes No
If so, are you claiming under Workers' Compensation Board? Yes No
Date of Injury: _____ Claim #: _____
Adjudicator: _____ Phone#: _____
Occupation: _____ S.I.N.: _____
Job Description: _____

Are you currently working? Yes No Date of last day: _____
Are modified duties available? Yes No
Which activities or movements are you having problems with? _____

EMPLOYER INFORMATION

Name: _____ Address: _____
Phone: _____ Fax: _____

How did you hear about our facility? _____

Medical and Past Health Questionnaire

Name: _____ Date: _____

Instructions: Please complete the following questionnaire. You may use the opposite side of the page if you require more space or wish to include additional comments.

1. Do you presently or have you ever suffered from any of the following illnesses?

| Illness | Yes | No | If yes, please provide date/details | Illness | Yes | No | If yes, please provide date/details |
|-----------------------------------|-----|----|-------------------------------------|---------------|-----|----|-------------------------------------|
| Diabetes | | | | Arthritis | | | |
| Heart Disease/ Attack / Angina | | | | AIDS or HIV | | | |
| Cancer | | | | Liver Disease | | | |
| Stroke | | | | TMJ Syndrome | | | |
| High Blood Pressure | | | | Asthma | | | |
| Thyroid Disease | | | | Other: | | | |

2. Have you ever undergone any of the following surgeries?

| Surgery | Yes | No | If yes, please provide date/details |
|------------|-----|----|-------------------------------------|
| Back/Spine | | | |
| Hernia | | | |
| Other: | | | |
| Other: | | | |

3. Have you had any past fractures?

| Bone | Yes | No | Date/Details | Bone | Yes | No | Date/Details |
|-----------|-----|----|--------------|------------|-----|----|--------------|
| Skull | | | | Pelvis | | | |
| Vertebrae | | | | Leg / Foot | | | |
| Ribs | | | | Arm / Hand | | | |
| Other: | | | | | | | |

4. Other

Are you taking any medications? Yes No Please specify: _____

Do any past health problems continue to affect your function? (ie, walk, dress, work)

Yes No Please specify: _____

Are you pregnant? Yes No How many months? _____

Do you smoke? Yes No How many/day? _____

Do you drink alcohol? Yes No How many/week? _____

Patient Signature: _____

Date: _____

RANSFORD PAIN DIAGRAM

On the drawings below, please indicate where you are experiencing pain by drawing in the letter abbreviation on the diagrams that most accurately reflect the type of discomfort that you have been experiencing.

Numbness = N
Sharp Pain = P

Tingling = T
Burning = B

Dull Pain = D
Stiffness = S

